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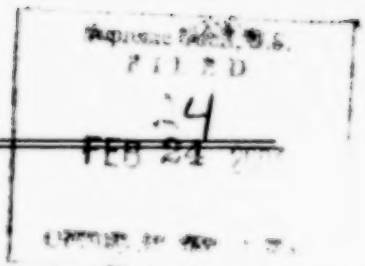

In The

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

APPENDIX TO PETITIONER'S BRIEF ON THE MERITS

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American Medical Association
Physicians dedicated to the health of America

[LOGO]

Guides

to the **Evaluation**
of **Permanent**
Impairment

Fifth Edition

Linda Cocchiarella, MD, MSc, AMA Medical Editor

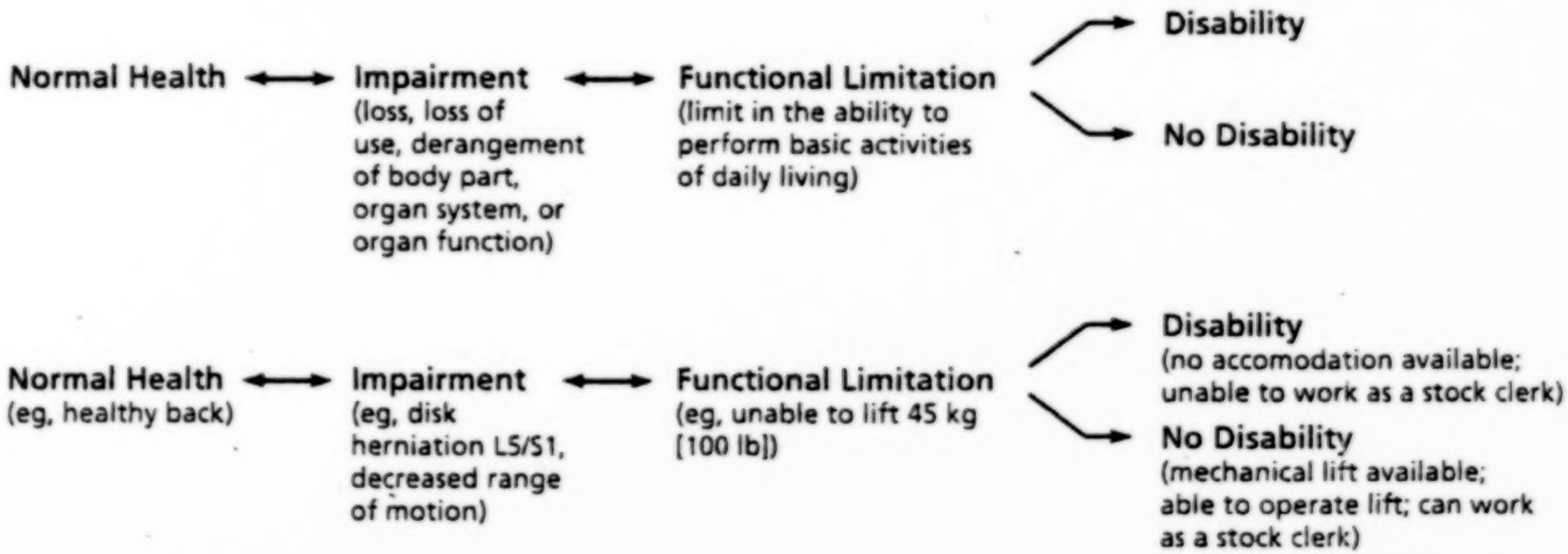
Gunnar B.J. Andersson, MD, PhD, Senior Medical Editor

AMA press

1.2b Disability

The term ***disability*** has historically referred to a broad category of individuals with diverse limitations in the ability to meet social or occupational demands. However, it is more accurate to refer to the specific activity or role the "disabled" individual is unable to perform. Several organizations are moving away from the term *disability* and instead are referring to specific *activity limitations* to encourage an emphasis on the specific activities the individual can perform and to identify how the environment can be altered to enable the individual to perform the activities associated with various social or occupational roles. (Table 1-1).

Figure 1-1 The Relationship Among the Concepts of Normal Health, Impairment, Functional Limitation, and Activity Disability (Performance Limitation)



According to a 1997 Institute of Medicine Report, "disability is a relational outcome, reflecting the individual's capacity to perform a specific task or activity, contingent on the environmental conditions in which they are to be performed." Disability is context-specific, not inherent in the individual, but a function of the interaction of the individual and the environment.

The World Health Organization (WHO) is revising its 1980 *International Classification of Impairments, Disabilities and Handicaps* and has released a draft document, *The International Classification of Impairments, Activities and Participation (ICIDH-2)*. The term *disability* has been replaced by a neutral term, *activity*, and limits in ability are described as *activity limitations*. The change in terminology arose for several reasons: to choose terminology without an associated stigma, to avoid labeling, and to emphasize the person's residual ability. Representatives worldwide are reviewing this international classification scale of impairments, function, and activities.

The *Guides* continues to define **disability as an alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment.** An individual can have a disability in performing a specific work activity but not have a disability in any other social role. Physicians have the education and training to evaluate a person's health status and determine the presence or absence of an impairment. If the physician has the expertise and is well acquainted with the individual's activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who

understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability.

The impairment evaluation, however, is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adapations can be made to the environment, the individual may not be disabled from performing that activity.

As discussed in this chapter and illustrated in Figure 1-1, medical impairments are not related to disability in a linear fashion. An individual with a medical impairment can have no disability for some occupations, yet be very disabled for others. For example, severe degenerative disk disease may impair the functioning of the spine of both a licensed practical nurse and a bank president in a similar fashion when performing their activities of daily living. However, in terms of occupation, the bank president is less likely to be disabled by this impairment than the licensed practical nurse. An individual who develops rheumatoid arthritis may be disabled from work as a tailor but may be able to work as a child care aide. A pilot who develops a visual impairment, correctable with glasses, may be able to perform all of his daily activities but is no longer able to fly a commercial plane. An individual with repeated hernias and repairs may no longer be able to life more than 20 kg (40 lb) but could work in a factory where mechanical lifts are available.

The *Guides* is not intended to be used for direct estimates of work disability. Impairment percentages derived according to the *Guides* criteria do not measure work disability. Therefore, it is inappropriate to use the *Guides'* criteria or ratings to make direct estimates of work disability.

1.2c Handicap

Handicap is a term historically used in both a legal and a policy context to describe disability or people living with disabilities. Though the term continues to be used, generally it is being replaced with the preferred term *disability*.

1.3 The Organ System and Whole Body Approach to Impairment

The *Guides* impairment ratings reflect the severity and limitations of the organ/body system impairment and resulting **functional limitations**. Most organ/body systems chapters in the *Guides* provide impairment ratings that represent the extent of whole person impairment. In addition to listing whole person impairments, the musculoskeletal chapters provide regional impairment ratings (eg, upper extremity, lower extremity); regional ratings are then converted into whole person impairment ratings. Within some musculoskeletal regions, a consensus group developed weights to reflect the relative importance of certain regions. For example, different fingers or different areas of the spine are given different weights, representing their unique and relative importance to the region's overall functioning. These weights, which have gained acceptance in clinical practice, have been retained to enable regulatory authorities to convert from a regional body to whole person impairment when needed.

1.4 Philosophy and Use of the Combined Values Chart

The **Combined Values Chart** (p. 604) was designed to enable the physician to account for the effects of multiple impairments with a summary value. A standard formula was used to ensure that regardless of the number of impairments, the summary value would not exceed 100% of the whole person. According to the formula listed in the combined values chart, multiple impairments are combined so that the whole person impairment value is equal to or less than the sum of all the individual impairment values.

18.3e Classes of Pain-Related Impairment

There are four general classes of impairment due to pain: class 1, mild; class 2, moderate; class 3, moderately severe; and class 4, severe (see Table 18-3).

Table 18-3 Impairment Classification Due to Pain Disorders

Class 1 Mild	Class 2 Moderate	Class 3 Moderately Severe	Class 4 Severe
Pain severity, based on a combination of intensity and frequency, is mild Individual's pain is mildly aggravated by performing ADL; is able to perform them with few modifications Individual demonstrates no or only minimal emotional distress in response to his or her pain Individual is not receiving treatment for pain on a regular basis Pain-related limitations during physical examination are mild and appear appropriate; few pain behaviors (overt expressions of pain, distress, and suffering, such as moaning, limping, moving in a guarded fashion, facial grimacing) are observed during examination	Pain severity, based on a combination of intensity and frequency, is moderate Individual has moderate difficulty managing ADL; must make significant modifications in order to perform them (eg, move to a ground floor apartment, buy a car with automatic transmission) Individual demonstrates mild to moderate affective distress in relation to his or her pain Individual requires ongoing medical monitoring and is taking medication much of the time Individual demonstrates significant pain-related limitations on physical examination; relatively few pain behaviors appear during the examination, and they are of indeterminate appropriateness	Pain is present most of the time and may reach an intensity of 9-10/10 Individual can perform ADL only with substantial modifications; unable to perform many routine activities (eg, driving a car) Individual demonstrates moderate to severe affective distress in relation to his or her pain Individual receives medication to control pain on a maintenance basis On physical examination, individual demonstrates severe pain-related limitations that may make the examination difficult to perform and results difficult to interpret A number of pain behaviors are observed during the examination, and they appear to be congruent with organ dysfunction	Pain is essentially continuous, with intensity reaching 9-10/10 at its worst Individual must either get help from others for many ADL (eg, preparing food, dressing), modify them drastically (eg, stop bathing), or spend an inordinate amount of time accomplishing them (eg, 2 hours to get out of bed and dressed) Individual demonstrates severe affective distress in relation to his or her pain and communicates the perception that the pain is completely out of control Individual is receiving maximal pharmacologic support for his or her pain on an ongoing basis Physical examination is virtually impossible to perform because individual is intolerant of many examination maneuvers (eg, refuses to ambulate or to allow examiner to palpate symptomatic area); a significant number of pain behaviors are observed during the examination, and they appear to be congruent with organ dysfunction

18.3f How to Rate Pain-Related Impairment: Practical Steps

There are six steps in the pain-related impairment evaluation process, each discussed below. Several alternative methods are available to evaluate the severity of pain, activity restrictions, emotional distress, and pain behaviors, some of which are discussed subsequently. One such methodology is provided in Table 18-4. The first three parts of the protocol included in Table 18-4 rely on the individual's self-report. The questions may be provided to the individual to complete on his or her own, or they can be presented in interview format. If the individual is asked to complete the questionnaire on his or her own, someone should be available to answer questions and to review the completed form to make sure the individual has responded to all the items. If the individual has a question about completion of any of the items in Sections I to III, he or she should be instructed to make the best estimate possible. Although Table 18-4 provides a numerical score, this should not be misunderstood to represent a quantitative impairment rating, but rather is used to classify individuals into the four qualitative classes. To that purpose, alternative methods may be used so long as they are valid and appropriately referred to in the report.

Table 18-4 Ratings Determining Impairment Associated With Pain

Name:_____ **Date:**_____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = _____

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____

Assess Whether the Individual is at MMI

This concept is particularly important in the assessment of pain-related impairment. A person should not be judged medically stable, and therefore ratable, unless he or she has undergone a thorough evaluation for the entire range of factors that can affect pain and has undergone a vigorous trial of rehabilitative treatment.

For example, there may be no further orthopedic interventions available for a lumbar pseudarthrosis. Spinal arachnoiditis may be refractory to any intervention. Yet in both cases, appropriate pain management may reduce all the components of impairment, with reduced pain severity, functional restoration, and mood normalization. Consultation with a specialist in pain medicine may be required to determine whether the impairment is fixed or potentially useful treatments are available.

Determine the Severity of the Pain

Although absolute quantification of pain is not possible, severity may be estimated using, for example, a visual analog scale, a numeric, or a box-rating scale. A horizontal or vertical line of known length is anchored by "no pain at all" at one end and "worst pain ever" at the other. A line of consecutive boxes also anchored with these end points, with a number in each one and in which the individual is asked to place an "X" in the box, may be of particular use because some people have difficulty understanding how to use a VAS scale. It is useful to obtain least, worst, and current levels, as well as the usual level. Exacerbating and mitigating factors should be sought. The character or

quality of pain may assist with diagnosis and help establish that the pain is compatible with a known medical syndrome.

The McGill Pain Questionnaire is widely used in pain medicine. It contains lists of words chosen to reflect the sensory (eg, dull, cramping), affective (eg, agonizing, terrifying), and evaluative (eg, annoying, unbearable) components of the pain experience. There are also descriptors of the temporal qualities of the pain (momentary, steady, intermittent). Line drawings of the body permit the individual to shade in the location of the pain. Numeric descriptors of the overall present pain intensity are provided (1 = mild, 2 = discomforting, 3 = distressing, 4 = horrible, 5 = excruciating).

Determine Activity Restrictions

The reported severity of pain may not correlate well with its functional impact. Indeed, some individuals report well-preserved function despite pain of 9/10 in severity, while others portray a vegetative existence with a pain level of 4/10. It is essential to know the extent to which the following functions are impeded by *pain*: ADL, socialization, recreation, work, sleep, sexuality, and cognition.

A quasi-quantification of functional status can be derived by scoring the extent to which pain interferes with each (applicable) activity. The individual should be queried as to how often he or she leaves the home (with documentation if housebound), gets out only for medical appointments, and the like. "Down time," the total number of hours a day the person is reclining, is a useful measure.

It is useful to provide quantification of functional limitations via accepted, standardized instruments that permit interrater comparisons. The Pain Disability Index provides 0 to 10 scales on which individuals rate pain-related interference in seven domains, including family/home responsibilities, recreation, social activity, occupation, sexual behavior, self-care, and life support activities (eating, sleeping, breathing). The SF-36 is widely used to determine the degree of functional impairment and changes in overall wellness following treatment of those with pain as well as of other populations. The Oswestry and Roland-Morris are brief questionnaires that provide an economical office assessment of function in individuals with back pain. A large number of other instruments exist, as reported in the literature. It is also possible to correlate estimates of function to actual impairment using questionnaires and scales.

The ADL listed in Table 1-2 are commonly classified within one of eight different areas: physical activity, nonspecialized hand activities, sleep, travel, self-care and personal hygiene, sexual function, communication, and sensory function. The first six of these are most relevant for impairment due to pain, as it is extremely rare for pain to create major restrictions in communication and sensory functioning. A number of measures have been developed to assess ADL, some of which are general and others of which are designed for use with specific diseases and injuries. Physicians may choose to select from among the available ADL scales if they wish a more detailed assessment. Although individuals may have difficulty separating the effect of specific diseases or injuries from the pain on their activities, some estimate is necessary to help in determining the extent of impairment due to pain that

exceeds activity restriction due to the disease or injury. For example, an individual with a below-the-knee amputation may have some activity limitations in ambulation; he or she may have additional limitations due to severe stump pain.

Several well-established general measures have been standardized on chronic pain sufferers and have been used in numerous published studies that may be of particular use as they assess several important domains relevant to the assessment of impairment. For example, the Sickness Impact Profile (SIP) is a widely used health status measure that has been shown to reliably assess the impact of health problems on function and quality of life. The West Haven – Yale Multidimensional Pain Inventory (MPI) is another reliable and valid health status measure that has been used extensively.

Determine the Presence of Emotional Distress

An important component of chronic pain-related impairment is its associated affective distress, which often includes sadness, anger or irritability, and anxiety. In some cohorts, the depression seems to be primarily a function of life interference and cognitive changes, while in others it seems to be primarily a function of the pain itself. In either case, it is unnecessary that an individual meet diagnostic criteria for a mood, anxiety, or other psychiatric disorder for there to be substantial suffering related to such issues as pain, loss of meaningful and pleasurable life activities, and a bleak future.

It may be appropriate to use rating scales to provide some quantification of affective changes. Brief self-administered screens for depression, such as the Beck Depression

Inventory, The Zung Depression Index, and rater-administered screens such as the Hamilton Self-rating Scale for Depression, may alert the physician to the presence of a mood disorder that requires treatment, as well as to the possibility of suicide. Similar instruments are available for anxiety and include the Beck Anxiety Scale and Hamilton Rating Scale for Anxiety. The Profile of Mood States (POMS), which has also been useful in providing quantification of various mood states in individuals with chronic pain, has scales reflecting impaired concentration, anxiety, depression, fatigue, and others.

As with pain reports, these instruments all are subject to minimization or exaggeration on the part of the individual. People are seen who score four times the cutoff for depression on the Beck Depression Inventory, yet who are animated and playful in the gym. When such discrepancies occur, the weighting given the instrument should be minimal. Moreover, caution must be taken in interpreting responses on these measures, as they are not standardized on samples of individuals with medical disorders, and using the usual cutoff scores may lead to an excessively large number of false positives.

It is important to obtain information from the individual regarding the impact of pain on his or her mood state. As noted in the discussion of activity restrictions, it may be difficult for the individual to separate the effect of specific diseases or injuries from the pain on activities; however, the items are designed to obtain a rough estimate of the individual's beliefs.

Determine if Pain Behaviors Are Present

Pain behaviors are the ways that individuals communicate about their pain. These behaviors may be verbal or nonverbal. The individual may be unaware of them, as they may be emitted and maintained due to responses that have been received from significant others, including health care professionals. In other instances, individuals may exaggerate their behaviors to signal pain and distress with the intent to achieve some desired response from those who observe the behaviors. Thus, both the antecedents and consequences of the behaviors are important.

Some individuals appear stoic as they go through evaluations, and the pain behaviors they do demonstrate are concordant with other medical information regarding their condition. In this instance, the pain behaviors provide valuable clues regarding a person's diagnosis and tend to validate the fact that he or she is suffering because of the diagnosed condition. For example, consider an individual with suspected degenerative joint disease of the hip who walks with a characteristic limp. The limp provides a clue to the diagnosis and tends to support the individual's reports that he or she has significant pain when walking.

At the opposite extreme, an individual may demonstrate pain behaviors that appear exaggerated and discordant with his or her presumed medical condition. These pain behaviors may appear to be driven by a variety of factors, such as overwhelming somatic anxiety or the person's desire to convince an examiner that he or she is suffering greatly. The common denominator underlying them is that they do not appear to be direct, inevitable consequences of a definable medical condition. Exaggerated, discordant

pain behaviors tend to cast doubt on the validity of the information that people provide regarding their condition.

Thus, an examiner has a twofold task regarding pain behaviors demonstrated by a person undergoing an impairment rating: to identify the pain behaviors, and to interpret their significance, that is, to decide whether they tend to authenticate the validity of the individual's suffering or to raise questions about his or her communication style.

It is hard to specify a generic list of pain behaviors. The behaviors to look for depend on the individual's medical condition, examination maneuvers that are performed, previous responses obtained, and intent. Physicians probably differ significantly in what they view as exaggerated pain behaviors. Sources of variation include different concepts of what represents "legitimate disease" and thresholds for calling a behavior abnormal.

Despite the limitations noted, pain behaviors provide useful information regarding both the impact of pain on observable behavior and the individual's style of communicating (eg, demonstrative, stoic) about their pain. The physician should observe the individual's pain behaviors as he or she enters the examination room, during the interview, and during the history taking. This will eliminate the increase in pain behaviors that might be directly associated with the physical examination.

The examiner should give a score between +10 and -10 to indicate his or her global evaluation of an individual's pain behavior during the interview and physical examination. A positive score is given when the individual demonstrates pain behaviors that are concordant with the overall clinical findings and, in the opinion of the examiner, tend

to authenticate his or her suffering. A negative score is given when an individual demonstrates grossly "nonorganic" or "exaggerated" pain behaviors. A score close to 0 should be given when the examiner is uncertain about how to interpret the individual's pain behaviors.

The specific behaviors an examiner considers vary according to the individual's medical condition and the examination maneuvers performed. Potentially significant behaviors that commonly occur during evaluations are listed in Table 18-5. Note that the significance of pain behavior cannot be determined unless related to a particular individual and context. Thus, a pain behavior that would be considered concordant in one clinical context would be considered discordant in a different one. Also, note that pain behaviors that tend to validate an individual's pain are generally specific to that person's medical condition. In contrast, exaggerated pain behaviors – such as emotional displays and pain-limited weakness – tend to occur in conjunction with a wide variety of medical conditions.

The physician can record the pain behaviors observed using the behaviors listed in Table 18-5. These behaviors may be viewed as indicating symptom magnification, especially when several are present and they grossly exceed what might be expected from individuals with a similar diagnosis. These systematic observations should be used as the basis for determining a global rating regarding the presence and congruence of pain behaviors given the individual's diagnosis and organ dysfunction.

Table 18-5 Assessment of Pain Behavior

Observable Pain Behaviors
Note the presence of any of the following behaviors during the interview and examination:
1. Facial grimacing
2. Holding or supporting affected body part or area
3. Limping or distorted gait
4. Frequent shifting of posture or position
5. Extremely slow movements
6. Sitting with a rigid posture
7. Moving in a guarded or protective fashion
8. Moaning
9. Using a cane, cervical collar, or other device
10. Stooping while walking
11. Other: _____
Based on the behaviors above and knowledge of the individual's diagnosis and organ dysfunction, rate the pain behaviors by giving them a score between +10 and –10. You may give any score between +10 and –10.

–10	**0**	**+10**
Pain behaviors are exaggerated, nonphysiologic	Pain behaviors are mixed or ambiguous	Pain behaviors are appropriate and tend to confirm other clinical findings

Global pain behavior score = _____

Credibility of the Individual

Physicians routinely assess the credibility of individuals in the course of their clinical work. This kind of assessment is particularly important in the context of rating pain-related impairment because the ratings depend on verbal and nonverbal behaviors of people that are at least partly under voluntary control. Although there are no definite rules for assessing credibility, Section 18.4, Behavioral Confounders, discusses several issues that a physician should consider when making a judgment about a person's credibility.

The key question the examiner should ask, is Do the limitations that an individual describes and demonstrates accurately reflect the burden of illness he or she bears during everyday activity?

18.4 Behavioral Confounders

An extensive literature demonstrates what common sense suggests: pain behaviors and perception of pain are strongly influenced by beliefs, expectations, rewards, attention, and training. In the absence of a direct measure of pain, such behaviors function as markers by which pain is judged. However, voluminous literature demonstrates that these markers reflect social and environmental factors as much as they reflect pain. It has been shown, for example, that individual ratings of pain severity diminish when "well talk" is reinforced. With repeated identical pain stimuli, intensity reports vary with feedback. Verbal reinforcement increases performance in individuals with back pain. Studies consistently show that spouse solicitousness is correlated with pain behavior.

Prospective studies consistently show that onset of disabling pain is highly associated with such factors as job dissatisfaction, lack of support at work, stress, and perceived inadequacy of income. Once initiated, the progression of pain to chronicity is contingent on similar factors. Financial compensation, receipt of work-related sickness payments, and compensation-related litigation are also associated with chronicity, as are such social and economic factors as poor education, language problems, and low income. Chronicity is also favored by individual tendencies to be preoccupied with one's body and symptoms. Even in individuals with clear-cut radicular pain from disk prolapse/protrusion, application for retirement at 6 months was best predicted by depression and daily hassles at work. In the case of injured workers, performance on functional capacity evaluation is reduced if the worker is informed that the test results will be used to determine work classification. Industrial injuries and compensation situations appear to provide a disproportionate number of individuals with such issues.

Although the suffering induced by a miserable vocational situation may equal or exceed that from disease or injury, it is the intent of the *Guides* to assign impairment based on disease and injury, not on such environmental situations as an individual's fear of returning to a hostile work environment. Similarly, the physician charged with assigning an impairment rating expects to discharge the obligation by assessing the state of the person as an organism, and he or she rightly considers such external factors as the state of the economy, the market for particular skills, and the local tolerance for language barriers to be distractors that lower the "signal-to-noise" ratio in the assessment.

Thus, examiners face a dilemma. They know that a variety of nonbiological factors strongly influence the disability status and ADL deficits of individuals they rate, but they are charged with the task of rating impairment on the basis of measurable dysfunctions of organ or body parts.

Physician Manipulation of Reimbursement Rules for Patients
Between a Rock and a Hard Place

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Context Health plan utilization review rules are intended to enforce insurance contracts and can alter and constrain the services that physicians provide to their patients. Physicians can manipulate these rules, but how often they do so is unknown.

Objective To determine the frequency with which physicians manipulate reimbursement rules to obtain coverage for services they perceive as necessary, and the physician attitudes and personal and practice characteristics associated with these manipulations.

Design, Setting, and Participants A random national sample of 1124 practicing physicians was surveyed by mail in 1998; the response rate was 64% (n = 720).

Main Outcome Measure Use of 3 different tactics "sometimes" or more often in the last year: (1) exaggerating the severity of patients' conditions; (2) changing patients' billing diagnoses; and/or (3) reporting signs or symptoms that patients did not have to help the patients secure coverage for needed care.

Results Thirty-nine percent of physicians reported using at least 1 tactic "sometimes" or more often in the last year. In multivariate models comparing these physicians with physicians who "never" or "rarely" used any of these

tactics, physicians using these tactics were more likely to (1) believe that "gaming the system" is necessary to provide high-quality care today (odds ratio [OR], 3.67; 95% confidence interval [CI], 2.54-5.29); (2) have received requests from patients to deceive insurers (OR, 2.44; 95% CI, 1.72-3.45); (3) feel pressed for time during patient visits (OR, 1.69; 95% CI, 1.21-2.37); and (4) have more than 25% of their patients covered by Medicaid (OR, 1.60; 95% CI, 1.08-2.38). Notably, greater worry about prosecution for fraud did not affect physicians' use of these tactics (P = .34). Of those reporting using these tactics, 54% reported doing so more often now than 5 years ago.

Conclusions A sizable minority of physicians report manipulating reimbursement rules so patients can receive care that physicians perceive is necessary. Unless novel strategies are developed to address this, greater utilization restrictions in the health care system are likely to increase physicians' use of such manipulative "covert advocacy" tactics.

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PHYSICIANS' DECISIONS ABOUT what services to offer their patients affect almost 80% of all health care expenditures and have an enormous influence on health care quality.[1,2] To control cost and quality and ensure adherence to their contracts, health care delivery organizations and payers frequently review physician recommendations and pay for services (eg, diagnostic tests, drugs, or hospitalization for treatment) only in predefined circumstances. This utilization review may occur prospectively, in the form of preauthorization; concurrently, requiring immediate approval over the telephone; or retrospectively, with payment decision being made after services have been delivered.

Specific utilization review criteria are rarely spelled out in advance; what physicians agree to when they sign health plan contracts varies greatly and may both alter and constrain physicians' decisions regarding their patients' use of services.

Although utilization review may be intended to improve quality and save money, many physicians and patients dislike conforming to its rules. Utilization review is often viewed as overly time consuming, a hassle, and an undue questioning of professional authority.[3,4] Appealing adverse coverage decisions may seem inconvenient, unproductive, or even risky for physicians. In some cases, physicians may feel trapped between professional obligations to advocate for their patients and conflicting contractual obligations to follow coverage rules. Furthermore, it has been suggested that some insurers are "gaming" patients and physicians – tricking them into paying for covered services by routinely denying coverage but then approving services that are subsequently appealed, knowing that time and other constraints will prevent some appeals.[4-6] To retaliate, physicians may be tempted to turn the tables.

Physicians could manipulate reimbursement rules to help their patients obtain coverage of care that the physicians perceive to be necessary, for example, through ambiguous documentation or by exaggerating the severity of patients' conditions.[7-9] This sort of deception of third-party payers has been called "gaming the system" for patients[5] and it is not a new idea, nor is it limited to managed care. Fee-for-service payment often provides a greater financial incentive for physicians to manipulate reimbursement rules since they directly profit from increased services. Yet recent data suggest that physicians

in regions with higher managed care penetration are more likely to condone manipulating reimbursement rules.[9] Some may believe that it is necessary to manipulate reimbursement rules in the course of patient advocacy today – even in the face of well-publicized crackdowns on fraud and abuse.[10-12] These physicians may see manipulation of reimbursement rules as an indirect, or convert, form of patient advocacy and even a professional obligation.

Previous studies have posed hypothetical coverage dilemmas to physicians and offered deception to physicians and offered deception of insurers as potential solutions.[9,13,14] These studies demonstrate that many physicians believe there are scenarios in which manipulating reimbursement rules would be justifiable in theory. Anecdotes suggest that using such tactics is not merely hypothetical but occurs in practice.[15] This study sought to determine how many physicians are manipulating reimbursement rules to get coverage for their patients' needed care, and what factors might affect how frequently physicians circumvent utilization review in practice.

METHODS

Physician Sampling

We performed a self-administered mailed survey of physicians in 1998, using a random sample of 1350 physicians from the American Medical Association (AMA) Masterfile of all physicians practicing in the United States. Physicians who were deceased, retired, or no longer seeing patients; who had moved with no forwarding address; or who were in training were excluded, bringing the final sample to 1124 eligible physicians.

Data Collection

Because of the sensitive legal nature of the survey questions, an independent survey research firm, the National Opinion Research Center at the University of Chicago, Chicago, Ill, conducted all mailings and telephone calls, and all potentially identifying information for respondents, including city of residence, was removed from the data set prior to its release to the research team. Respondents were informed in the cover letter that the information would remain strictly confidential. It is not possible to track data back to identifiable individual respondents or health plans using the hard copies of the surveys. The study protocol was approved by an independent institutional review board (Western IRB, Olympia, Wash).

Questionnaires were mailed with a modest financial incentive enclosed (average value, $10). Those who did not respond to the initial mailing of the survey received up to 3 follow-up mailings and 2 telephone calls. In the second call, physicians were given the opportunity to respond by telephone interview.

Variables

Dependent Variable. Questionnaire items were developed from the literature,[3] from a 1996 pilot survey of 134 physicians attending a professional meeting,[7] and from a focus group of practicing physicians. Our dependent variable was whether the physician had manipulated reimbursement rules "to help patients secure coverage for needed treatments or services" in the last year. This was operationalized as the frequency of using 3 general strategies: exaggerating the severity of the patient's condition, changing the patient's official (billing) diagnosis, and/or

reporting signs or symptoms that the patient did not have. These 3 items were each reported on 5-point Likert scales ("never" to "very often"). Descriptive statistics showed that all 3 of these variables had skewed distributions, and, using confirmatory factor analysis, we determined that the 3 items clustered together and the resulting scale had acceptable internal consistency reliability (Cronbach α = .68). Therefore, we felt it was appropriate to use these 3 variables to create a dichotomized summary variable for a multivariate model. Based on their distributions, we made an a priori decision (ie, before examining results of bivariate and multivariate analyses) to dichotomize each of these variables such that "never" and "rarely" were in 1 group and "sometimes," "often," and "very often" were in the other. The 3 items were then aggregated into a single dichotomous variable such that those who answered "never" or "rarely" to all 3 items were in 1 group and all other physicians were in the other.

Independent Variables. We hypothesized that a number of personal and practice characteristics might affect a physician's propensity to manipulate reimbursement rules. We examined characteristics such as number of years in practice; specialty; country of origin, employment type; average number of patients seen each week; number of managed care contracts; proportion of income from capitated, fee-for-service, or salary payments; and total proportion of income at risk for the costs of patient care.

We assessed physicians' attitudes using a series of items that asked for agreement or disagreement on a range of statements, using 5-point Likert scale responses ("strongly agree" to "strongly disagree"). Each of these items was collapsed for analysis into 3 categories: those

who agreed (including "agree" or "strongly agree"), those who disagreed (including "disagree" or "strongly disagree"), and those who were not sure.

One item asked whether physicians agreed that "today it is *necessary* to game the system to provide high-quality care" (italics in the original). Three statements were designed to measure whether the respondent believed that "gaming the system" was a legitimate part of patient advocacy: (1) "In general, it is ethical to game the system for your patient's benefit"; (2) "It is a physician's responsibility to advocate for his/her patient's needs even if it involves exaggerating the severity of the patient's condition to third parties"; and (3) "Assuming your intent is to further a patient's interest, exaggerating the severity of a patient's condition to an insurer is okay." These items were intercorrelated (all correlation coefficients >0.5) so that only the results for item 1 are reported. Other items addressed numerous potentially relevant attitudes and experiences, including "All things considered, I am satisfied with my medical practice"; "I feel financially secure"; "Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third parties"; and "I have enough time with each patient to get everything done that I need to."

Three statements addressed physicians' perceptions of the inconvenience involved in the utilization review process: (1) "Appealing an adverse utilization decision usually takes an excessive amount of my own time"; (2) "I find insurance company intrusion into medical decision making extremely annoying"; and (3) "Appealing adverse utilization decisions is a tremendous hassle." We used these items to form a 3-to-15-point scale confirmed by factor analysis (Cronbach α = .68), which we call the

Hassle of Utilization Review Scale. Physicians scoring higher on this scale felt more inconvenienced by utilization review. Finally, physicians were asked how often in the last year patients had requested that the physician "in some way deceive their third-party payer to help them secure coverage for a service."

Analyses

Bivariate relationships between the dichotomous summary gaming variable and each independent variable were assessed using *t* tests for comparisons that used continuous variables and x^2 tests for those that used ordered variables. Variables with bivariate relationships to the dependent variables of $P \leq .20$ were candidates for the multivariate model. Multivariate logistic regression models were estimated using forward and backward selection methods. Identical independent variables were significant using both criteria, so a straight-entry model was created using those variables, and those results are presented. To obtain adjusted odds rations (ORs) in these models, continuous variables were dichotomized at reasonable cut points based on their distributions and clinical importance. For categorical variables with "agree," "disagree," and "not sure" categories, the "agree" and "not sure" categories were each compared with the "disagree" category. One categorical variable ("How often have your patients requested that you in some way deceive their third-party payer to help them secure coverage for a service?") had 5 response options, from "never" to "very often." This variable was dichotomized by collapsing the "never" and "rarely" categories and the "sometimes,"

"often," and "very often" categories. All analyses used in the SPSS statistical program (SPSS Inc, Chicago, Ill).

RESULTS

Respondent Characteristics

The 720 physicians (response rate, 64%) who completed the questionnaire did not differ from nonrespondents on any available demographic variables. Respondents represented a range of incomes, types of practice, and specialties, as shown in TABLE 1. Most (80%) were men, had been in practice more than 10 years (mean, 17 years), and were in active clinical practice (seeing a mean of 86 patients per week). In all but 1 respect, the demographic frequencies in Table 1 are also similar to available national statistics.[16] For unexplained reasons, our overall random sample contained a larger-than-usual proportion of foreign-born physicians (nearly 40%) compared with nationally (27% in the AMA Masterfile; Tom Pasco, written communication, July 21, 1999). However, foreign-born physicians were not more likely to complete the questionnaire and there were no differences in our dependent variable or its components between foreign-born and US-born physicians.

Table 1. Characteristics of Survey Respondents and Nonrespondents*

	Respondents	Nonrespondents	*P* Value†
Male sex, No. (%)	573 (80)	316 (81)	.68
Employment type, No. (%)			
Self-employed	218 (30)	103 (26)	.57
Group practice	277 (39)	137 (35)	
Hospital/medical school employee	78 (11)	53 (14)	
Other	147 (20)	99 (25)	
Country of origin, No. (%)			
United States	431 (59.9)	234 (59.7)	.97
Canada	8 (1.1)	5 (1.3)	
Other	281 (39.0)	153 (39.0)	
Population of practice area, No. (%)			
Metropolitan (≥50 000)	627 (87)	348 (89.9)	.42
Nonmetropolitan (<50 000)	83 (12)	39 (10.01)	
Specialty, No. (%)‡			
General internal medicine	85 (11.6)	. . .	. . .
Family practice	96 (13.3)	. . .	. . .
Pediatrics	72 (9.9)	. . .	. . .
Internal medicine subspecialties	90 (13)	. . .	. . .
Surgical specialties	159 (23)	. . .	. . .
Other	199 (28)	. . .	. . .
Years of practice, mean (median)	17 (13)	. . .	. . .
No. of patients per week, mean (median)	86 (80)	. . .	. . .
Annual income, No. (%)			
≤$149 000	336 (48)	. . .	. . .
$150 000-$249 000	247 (34)	. . .	. . .
≥$250 000	107 (15)	. . .	. . .
Income at risk for the costs of patient care, mean (median), %	14 (5)	. . .	. . .
Physicians who report any recent practice-related income loss, No. (%)	313 (44)	. . .	. . .
Source of income, mean (SD), %			
Fee-for-service payments	21 (37)	. . .	. . .
Salary payments	23 (39)	. . .	. . .
Capitated payments	3 (12)	. . .	. . .
No. of managed care contracts, mean (median)	12.3 (6)	. . .	. . .
Medicare recipients, mean (median), % of patients	28 (25)	. . .	. . .
Medicaid recipients, mean (median), % of patients	17 (10)	. . .	. . .

*Ellipses indicate data not available. Percentages may not sum to 100 due to rounding.
†Data were calculated using the 2-tailed χ^2 test.
‡Data shown were collected directly from respondents (primary data) and are not comparable with American Medical Association Masterfile data. Primary data are more reliable than Masterfile data in regard to specialty, so primary data were used for subsequent bivariate and multivariate analyses. When Masterfile data comparing respondents' and nonrespondents' specialties were analyzed (not shown), only small differences were found within specialties, though some were statistically significant. Using Masterfile data, the strongest statistical finding was that among surgeons, there was a slightly higher percentage of respondents than nonrespondents (19.4% vs 14.9%; $P<.001$). The 3 primary care specialties (general internal medicine, family practice, and pediatrics) were collapsed to a single category (primary care physicians) for bivariate and multivariate analyses.

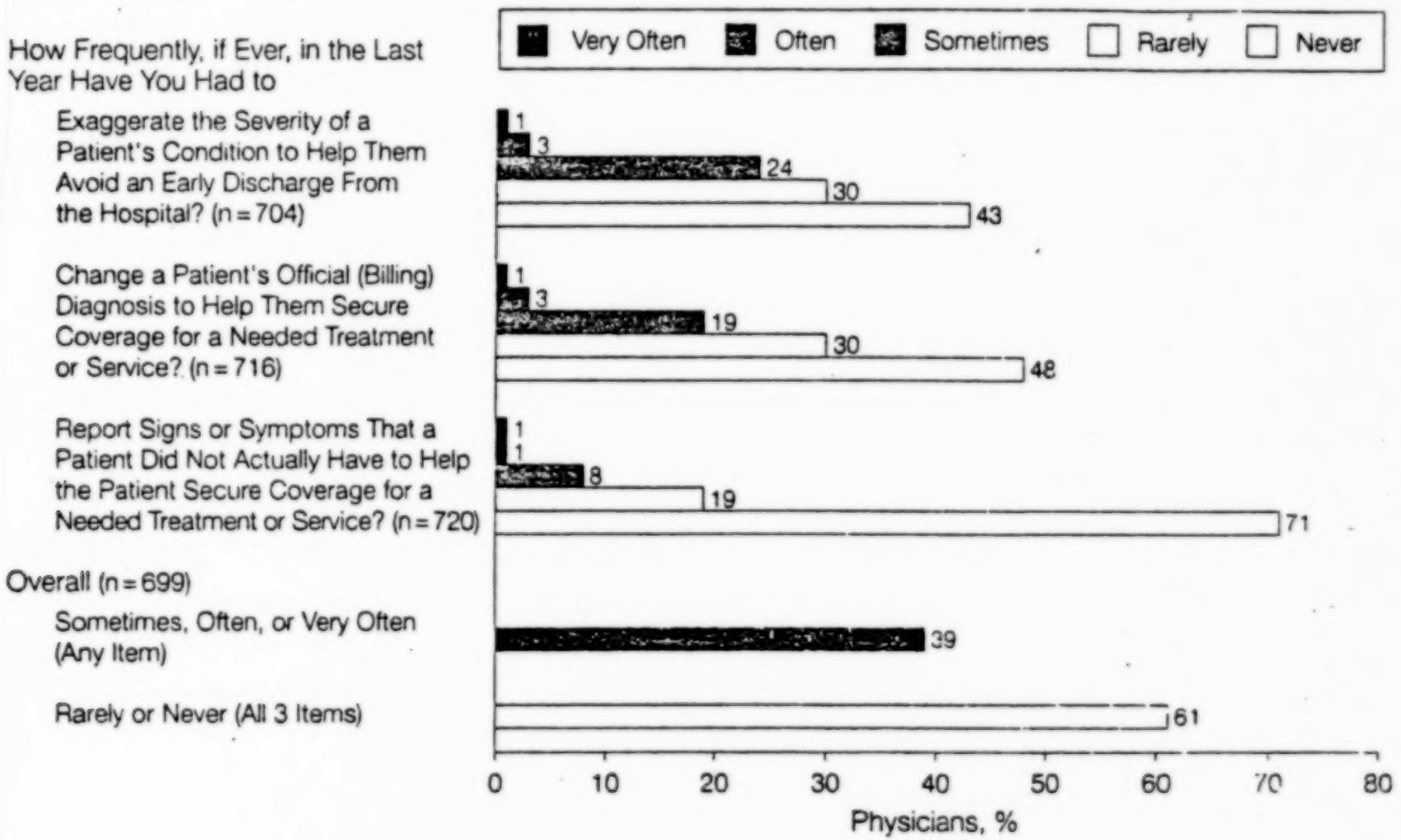
Frequency of Manipulation

The FIGURE shows physicians' reported use of 3 ways to manipulate reimbursement rules, using the exact wording of the survey items. Exaggerating the severity of patients' conditions to help them avoid early hospital discharge was the most commonly used tactic, with 28% of respondents reporting that they had done this sometimes or more often in the last year. Almost as many respondents (24%) reported having changed patients' official (billing) diagnoses, while 10% had recorded signs or symptoms that patients did not actually have to help them secure coverage for needed care.

Altogether, 275 physicians (39%; Figure) reported that they had sometimes, often, or very often used at least 1 of the 3 tactics for manipulating reimbursement rules, and 424 (61%) had rarely or never used any of the tactics in the last year. While we dichotomized respondents in this way to create our dependent variable for subsequent analyses, it may be of interest that 193 respondents (28%) reported never using any of the 3 tactics, while only 3 physicians (0.4%) reported using all 3 tactics often or very often and 49 (7%) reported using at least 1 manipulative tactic often or very often.

We also asked each physician who reported using any of these 3 tactics in the last year whether "you find yourself using deception of third-party payers to obtain needed benefits for patients" more or less often now than 5 years ago. Fifty-four percent responded "more often," while 12% reported doing so less often and the rest said it was unchanged.

Figure. Frequency of Physicians' Use of 3 Tactics to Manipulate Reimbursement Rules



Physicians' Attitudes and Experiences

As shown in TABLE 2, 28.5% of physicians agreed with the statement, "Today it is *necessary* to game the system to provide high quality care" and 15.3% agreed with the statement, "In general it is ethical to game the system for your patients' benefit." These 2 items were strongly associated ($x^2_{16} = 187.5$; $P<.001$); among those who believed that gaming the system is necessary, 42.9% also believed it was ethical, while among those who did not think gaming is necessary, only 4.2% believed it was ethical. Given this significant association, only the first item was used for subsequent statistical analyses, yet it is of interest that even among those who believed that gaming the system is necessary, the majority (57.2%) did not believe that it was ethical.

The Hassle of Utilization Review scale had a mean score of 12.8 (median, 13; range, 3-15). The middle value for this scale was 9, so a mean of 12.8 indicates that, on average, physicians fell between "agree" and "strongly agree" on these items. Roughly 58% of physicians were satisfied with their practice, 47% felt financially secure, 57% reported that worry about prosecution for fraud might prevent them from exaggerating patients' conditions to third-party payers, and 44% believed they had enough time with each patient to get everything done that they needed to. Finally, more than 1 in 3 physicians (37%) reported that their patients sometimes, often, or very often requested that they deceive third-party payers to help them obtain coverage for services in the last year.

Table 2. Physicians' Agreement With Selected Statements Related to Attitudes and Experiences Regarding Manipulating Reimbursement Rules (N = 720)*

Variables	Response, %
Today it is *necessary* to game the system to provide high-quality care	28.5
In general, it is ethical to game the system for your patients' benefit	15.3
Hassle of Utilization Review scale score, mean (SD) [range]†	12.8 (2.2)[3-15]
All things considered, I am satisfied with my medical practice	58.3
I feel financially secure	47.4
Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third parties	56.5
I have enough time with each patient to get everything done that I need to	43.6
Patients request that I deceive their third-party payer‡	37.0

*Response includes percentage responding "agree" or "strongly agree," unless otherwise noted.

†The Hassle of Utilization Review scale rated a combination of 3 statements, including (1) "Appealing an adverse utilization decision usually takes an excessive amount of my own time"; (2) "I find insurance company intrusion into medical decision making extremely annoying"; and (3) "Appealing adverse utilization decisions is a tremendous hassle." See "Methods" section of text for more information.

‡Response includes percentage responding "sometimes," "often," or "always."

Table 3. Significant Bivariate Relationships of Independent Variables to Manipulating Reimbursement Rules

Variables	% Reporting Manipulation of Reimbursement Rules*		*P* Value for Difference
	Yes	No	
Patients request that I deceive their third-party payer, "sometimes," "often," or "always"	50.5	27.2	<.001†
Today it is *necessary* to game the system to provide high-quality care, "agree" or "strongly agree"	64.3	35.7	<.001†
Hassle of Utilization Review scale score, mean (range, 3-15)	13.2	12.4	<.001‡
I have enough time with each patient to get everything done that I need to, "agree" or "strongly agree"	35.8	48.8	<.001†
More than 25% of patients covered by Medicaid, %	20.6	15.3	.002‡
All things considered, I am satisfied with my medical practice, "agree" or "strongly agree"	51.6	63.0	.003†
I feel financially secure, "agree" or "strongly agree"	40.4	52.6	.002†
Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third-party payers, "agree" or "strongly agree"	42.3	57.7	.04†

*Physicians who used at least 1 of the tactics shown in the Figure sometimes or more often in the last year were classified as "yes." Physicians who rarely or never used any of the 3 tactics were classified as "no" (see "Methods" section of text).

†*P* values were calculated using the χ^2 test.

‡*P* values were calculated using the 2-tailed *t* test.

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Bivariate Analyses

Physicians who reported manipulating reimbursement rules were almost twice as likely to report patient requests to deceive third-party payers as those who did not (50.5% vs 27.2%; $P<.001$; TABLE 3). Physicians who agreed with the statement, "Today it is *necessary* to game the system to provide high-quality care" reported manipulating reimbursement systems more often than those who did not agree with the statement (64.3% vs 35.7%; $P<.001$). The mean score on the Hassle of Utilization Review scale was also significantly higher for those who reported manipulating reimbursement rules compared with those who did not (13.2 vs 12.4; $P<.001$). Perceptions of time pressure during office visits were positively correlated with physicians' decisions to manipulate reimbursement rules; those who reported using these tactics were less likely to agree with the statement that they have enough time with patients to get everything done that they needed to (35.8% vs 48.8%; $P<.001$). Physicians who manipulate reimbursement rules also reported a somewhat higher percentage of patients receiving Medicaid (20.6% vs 15.3%; $P = .002$), were less satisfied with their medical practice (51.6% vs 63.0%; $P = .003$), and felt less financially secure (40.4% vs 52.6%; $P = .002$) compared with physicians who reported rarely or never using these tactics. Those who reported manipulating reimbursement rules were less likely to agree that worry about prosecution for fraud would prevent them from exaggerating patients' conditions to third parties (42.3% vs 57.7%; $P = .04$). Other variables, including physician demographics (specialty, sex, rural practice, physician country of origin, and years of practice); primary payment by fee for service, capitation, or salary; physician income; and number of managed care contracts, were not

associated with manipulating reimbursement rules for patients (P>.20 for all).

Multivariate Analyses

In the multivariate model, a physician's belief that gaming the system is necessary to provide high-quality care remained the strongest predictor of manipulating reimbursement rules. As shown in TABLE 4, those who agreed with this statement were more likely to report having manipulated reimbursement rules compared with those who disagreed or were not sure (OR, 3.67; 95% confidence interval [CI], 2.54-5.29). Having patients who requested that physicians deceive third-party payers was also strongly associated with manipulating reimbursement rules, with those who received such requests being more likely to use these tactics (OR, 2.44; 95% CI, 1.72-3.45). Similarly, physicians who reported not having enough time with each patient had significantly higher odds of reporting manipulating reimbursement rules (OR, 1.69; 95% CI, 1.21-2.37), as did those with more than 25% of their patients covered by Medicaid (OR, 1.60; 95% CI, 1.08-2.38). Two negative findings from the multivariate model also merit mention. First, the physician's level of financial security was no longer related to physicians' manipulation of reimbursement rules (P = .11). Second, physicians who reported worrying about prosecution for fraud were not less likely to report manipulating reimbursement rules (P = .34).

Table 4. Results of Multivariate Logistic Regression Model Used to Determine Significant Factors Associated With Physicians' Reported Manipulation of Reimbursement Rules

Variables	Adjusted Odds Ratio	95% Confidence Interval
Today it is *necessary* to game the system to provide high-quality care*	3.67	2.54-5.29
Patients request that I deceive their third-party payer†	2.44	1.72-3.45
Not enough time with each patient*	1.69	1.21-2.37
More than 25% of patients covered by Medicaid	1.60	1.08-2.38

*Odds ratios compare those responding "agree" or "strongly agree" with those responding "disagree" or "strongly disagree."

†Odds ratios compare those responding "sometimes," "often," or "always" with those responding "rarely" or "never."

COMMENT

In this study of a nationally representative sample of physicians, we sought to determine how frequently physicians manipulate reimbursement rules to help their patients secure coverage for care that the physicians perceive to be necessary. Unlike previous studies, which have examined whether physicians might condone gaming the system under hypothetical circumstances,[9,13,17] we were interested in estimating how often physicians actually use deceptive tactics in the current health care system and whether certain factors might be increasing this frequency. We found that 3 different ways of manipulating reimbursement rules were all relatively uncommon but far from rare; between 10% and 27% of physicians reported using each tactic "sometimes" or more often in the last year to help patients obtain coverage. Added together, while the majority of physicians (61%) reported rarely or never exaggerating patients' severity of illness, changing patients' billing diagnoses, or reporting signs or symptoms that patients did not have in the last year, the rest (39%) reported using 1 or more of these tactics at least sometimes. In a multivariate model, the belief that gaming the system was necessary to get patients needed care, more requests from patients to deceive payers, believing that visit lengths were too short to get everything done that they needed to do, and having more than 25% of one's patients covered by Medicaid were independently and significantly associated with having manipulated reimbursement rules in the last year.

Physicians might manipulate reimbursement rules to benefit patients, themselves, or both. Since the financial

and health-related interests of patients and physicians can coincide, it is impossible to completely separate these motivations. However, 2 aspects of our findings suggest that financial self-interest is not the sole motivation for most physicians who manipulate reimbursement rules. First, manipulation of reimbursement rules was most common in the situation in which an individual physician could not possibly provide free or reduced-cost care (ie, hospitalization). Physicians may reserve gaming the system for situations in which free care cannot be offered. Second, to our surprise, we found no association between manipulation of reimbursement rules and any of the financial markers we examined, such as proportion of income at risk, principal type of reimbursement (fee for service vs capitation or salary), or recent practice-related income losses. Although the physician's perceived level of financial security was significant at the bivariate level, it was not significant in the multivariate model. Physicians with potentially greater financial stakes in manipulating reimbursement rules did not report doing so more often.

Not surprisingly, physicians who reported manipulating reimbursement rules were much more likely to believe that gaming the system is necessary to provide high-quality care today. Of perhaps more importance is that physicians who believed that gaming the system for patients is necessary were also significantly more likely to believe that it is ethically acceptable, indicating some degree of ethical adaptation to perceived necessity. However, even among physicians who reported that gaming is necessary, the majority still did not believe it is an ethical practice. This accords with the strongly worded official declarations of professional societies, wherein manipulating reimbursement rules is considered an ineffective and

socially irresponsible way to advocate for patients' interests.[18-20] These and other ethical arguments against gaming reimbursement systems are well developed.[5,8,18,19,21,22] Yet, although the AMA and others have consistently opposed the manipulation of reimbursement rules, regardless of intent, and though most physicians agree with this position, some nevertheless appear to view this advice as untenable given their immediate patient care obligations. Moreover, in the face of the current crackdown on fraud and abuse,[11,12] it is interesting that worry about prosecution for fraud did not seem to inhibit physicians from manipulating reimbursement rules to obtain coverage for needed care. Thus, neither ethical pronouncements nor further fraud and abuse enforcement are likely to be very effective in deterring manipulations of reimbursement rules among physicians who see it as the only feasible way to provide high-quality care.

Many physicians who reported manipulating reimbursement rules also reported receiving patient requests to deceive third-party payers. This suggests that both physicians and patients may not view current utilization review processes as legitimate or responsive to their needs. However, physicians could also be manipulating reimbursement rules in response to patient requests for another reason. Some might be deceiving insurers rather than confronting patients who present with unreasonable demands. Manipulating reimbursement rules may be easier and less time-consuming than attempting to explain to patients why a requested intervention is marginally beneficial or unnecessary, or exploring whether it could be paid for out-of-pocket by the patient.

Increasing time pressures have been linked to poorer health outcomes[23] and possibly increased malpractice

claims.[24] We found that feeling pressed for time is also associated with increases in manipulating reimbursement systems among physicians. This could reflect the time required to pursue regular advocacy routes, such as filing formal appeals. When time pressures make using regular advocacy routes inconvenient or impossible, physicians may be tempted to use covert advocacy tactics, such as manipulating reimbursement rules, to help their patients obtain needed care. We do not have information on the specific health plans in which manipulating reimbursement rules occurred and whether regular appeals processes were readily available, but manipulating reimbursement rules might be perceived to be the most rapid and convenient short-term way to obtain services in some situations.

It is not clear from these data why having more than 25% of one's patients covered by Medicaid is associated with a higher propensity to report manipulating reimbursement rules. Medicaid reimbursement rates are often lower than those of commercial payers, so accepting more Medicaid patients may put financial stresses on physicians that increase the perceived need to game the system to achieve target incomes. Some individuals are also more willing to mislead government entities than smaller exterprises.[25] Medicaid plans may also carry out more stringent or more intrusive utilization review, or patients covered by Medicaid simply may need more services and, hence, present more potential opportunities for physicians to manipulate reimbursement rules.

Although many physicians report manipulating reimbursement rules to help their patients obtain coverage for care that the physicians perceive to be necessary, the majority report doing so rarely or never. From these

data, we cannot tell whether this is because they did not have to or because they chose other avenues to obtain the care, or whether their patients did not receive needed care. The last scenario would be particularly worrisome for patients and their physicians, in part because current case law suggests that physicians are legally accountable for providing needed care and that they do not derive legal immunity by agreeing to accept health plan coverage rules.[26,27] That is, compliance with health plan rules does not provide protection against malpractice litigation and losses stemming from failure to provide an acceptable standard or care. Of course, failure to adhere to health plan coverage rules and manipulating these rules, even to benefit patients, also has potential legal repercussions.[10]

This study has several important strengths. We surveyed a random sample of physicians nationwide, including all specialties, and achieved a suitable response rate despite the controversial topic. For the first time that we are aware of, physicians were asked to report the frequency of actually manipulating reimbursement rules in practice. In previous studies, researchers have used second- or even third-party hypothetical scenarios to explore these behaviors.[9,13,14] While using hypothetical scenarios may be less threatening to respondents, it cannot address key issues in contention, such as whether these scenarios arise in practice and whether physicians really act as they say they might. Another strength is that we asked only about manipulating reimbursement rules to help patients obtain coverage for care that the physicians perceived to be necessary. While we cannot ascertain whether the physicians' judgments of medical necessity were accurate, we intentionally avoided issues of

large-scale fraud that the Health Care Financing Administration and others have primarily targeted, such as billing for services not rendered, kickbacks, and self-referral.[10] Most physicians oppose such activities, so they pose no real ethical dilemmas. Since we wished to address the frequency of physicians facing true ethical dilemmas due to reimbursement policies, the situations we addressed were intentionally ethically challenging, with no clear "right" answer.

There are several relevant study limitations. We could not independently confirm reported acts of manipulating reimbursement rules for patients. If there were a systematic reporting bias, however, we believe that it was in the direction of underreporting. Although we tried to frame the survey questions in neutral tones, the words *game* and *deception* were both used in some items and these words have negative connotations. Combining this socially desirable response bias with the perceived legal risk involved in admitting to using these tactics, it is likely that respondents underreported how often they manipulate reimbursement systems. A second limitation, with a similar underreporting bias, is that we only asked about 3 general ways in which physicians might manipulate reimbursement rules to help patients obtain care. It is likely that there are other ways of manipulating reimbursement rules that we did not address.

There are no simple solutions to the problem of physicians manipulating reimbursement rules for their patients. The root causes of this problem are tensions that are structural, largely unavoidable, and likely to become increasingly intense. These tensions reflect an underlying uncertainty as to whether health care is best viewed in a market-based contractual model or a profession-based

fiduciary model, when both models have ethical and legal strengths. A contractual model of health care, wherein patients and physicians are closely held to their written agreements with health plans and insurers, supports the compelling ethical principle of contractual justice.[28] And American society is leaning strongly toward a market-oriented emphasis on value for money and free choice in health care. Patients with good information and options should "get what they pay for." On the other hand, physicians traditionally act as their patients' agents (fiduciaries) and strive to provide an equally high standard of care to all, regardless of what individual patients can afford to pay.[29] It is well-known that many patients are not "good" health care consumers,[30,31] and can unwittingly agree to or be assigned to contracts that may not fully serve the r medical needs. Bending the rules for patients to provide a high-quality standard of care may be seen as an act of beneficence, or mercy, which is also ethically compelling.[32] While insurance policies are contracts between patients and insurers, our findings suggest that some physicians believe that strictly enforcing these contracts is contrary to their professional role as patients' agents and caregivers.

Physicians are thus caught in 2 sets of conflicting demands. Legally, physicians are contractually bound to adhere to reimbursement policies yet are also liable for failure to deliver an equally high standard of care to all patients, regardless of ability to pay. Ethically, physicians are caught between the compelling principles of social justice on the one hand and beneficence, or mercy, on the other. We can document the effects of these tensions and perhaps find ways to alleviate them, but the question no

empirical study can answer is, "When, if ever, is it 'good' for a contract to be broken in a surreptitious act of mercy?"

Without answering this question, our findings still have several practical implications. As pressures to control health care costs increase, it is likely that manipulating reimbursement systems will increase in parallel. Efforts to more tightly control utilization will likely increase physicians' perceived need to manipulate reimbursement rules to provide high-quality care and will increase patients' requests for the services being controlled. Further attempts to reduce physician reimbursement will put pressures on physicians to increase patient volumes, necessarily reducing the time physicians and patients spend with each other. Our findings suggest that such conditions will be associated with more covert manipulation of reimbursement rules, and that enforcement of fraud and abuse statutes will not alleviate this. On the other hand, possible approaches to minimize the perceived need for physicians to manipulate reimbursement rules might include providing adequate time for patient-physician discussions and involving physicians and patients in benefits determinations and utilization review processes. In our view, making utilization review procedures more user-friendly might encourage patients and physicians to use legitimate advocacy channels. Physicians and patients who are positively disposed to a utilization review system and who view its processes as legitimate, responsive, and non-punitive might be less tempted to manipulate it covertly for their own benefit. But attaining this goal must involve patients and physicians becoming committed to the social systems through which coverage decisions are made and overcoming their apparently high levels of cynicism regarding the effectiveness and fairness

of these systems today. Finally, as a market for systemic problems, evolving systems of care delivery could be individually assessed for their effects on physicians' perceived need to covertly manipulate reimbursement rules to provide high-quality care. Health plans in which the use of these tactics is common should carefully review their rules and procedures and work with physicians to reduce the perceived need for covert advocacy.

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Disclaimer: The views and opinions contained in this article are those of the authors and should in no way be construed as representing the official policies of the American Medical Association.

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PRACTICING LAWYER

Psychotherapist testimony in PI cases: coping with the stealth evaluation

by Eric G. Mart

It is only in recent years that the serious and sometimes chronic negative effects of psychological trauma have come to be recognized by the mental health professions. For decades, trauma-related symptoms were thought to be the result of intrapsychic conflicts and unconscious processes. In the last decade, however, mental health professionals have begun to recognize and understand the effects of both chronic and acute trauma. Patients who in an earlier time would have been diagnosed as having borderline personalities, depressive neuroses or phobias are now seen as suffering with conditions resulting from their traumatic experiences.

In the face of this new understanding, the legal system has changed the way in which injuries are compensated. In addition to punitive damages and compensation for pain and suffering and loss of income, courts have begun to allow compensation for the intentional or negligent infliction of psychological distress. Claims for

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emotional distress have become common, both as a component of personal injury cases and as the sole basis for actions.

Unfortunately, not all claims for compensation are valid, and the legal system's recognition of psychological trauma has opened the door for cases of dubious merit. Post Traumatic Stress Disorder, for example, has become the "junk back" of the 90s. The symptoms of PTSD are widely known and relatively easy to malinger. While many individuals are genuinely traumatized by experiences beyond normal human experience, a certain percentage of psychological trauma claims are false.

Bona fide vs. bogus claims

The court's problem of sorting through psychological damage claims to separate the bone fide from the bogus is complicated by certain types of expert testimony of mental health professionals, what I have heard referred to as the "stealth evaluation." Understanding the difference between this type of testimony and legitimate testimony requires some explanation.

In most jurisdictions, the testimony of a mental health professional is required in order to authenticate claims of psychic trauma. This means that a mental health professional who is qualified by the court must testify that the plaintiff is traumatized and that the proximate cause of the trauma was the act of negligence or malice in question. The assessment of this type of trauma by a forensic psychologist or psychiatrist is a complex undertaking, requiring specialized assessment skills, techniques and training.

Even with the aid of these skills, the diagnosis of bone fide trauma and assessment of proximate cause is a challenging task.

The stealth evaluation is often an attempt to circumvent this process while increasing the probability that the psychic damage claim will be seen as bone fide. After hearing the plaintiff's version of the alleged traumatic events, the plaintiff's attorney suggests that therapy is needed to help the plaintiff cope with the traumatic experiences and symptoms. The plaintiff sees a therapist for some length of time for therapy before the trial. At the trial, the therapist testifies that the plaintiff has symptoms consistent with PTSD and that the cause of these symptoms was more likely than not the actions or negligence of the defendant.

Advocacy or assessment?

What makes this a stealth evaluation? It is the fact that it is not an evaluation at all, but rather advocacy masquerading as assessment. Assessment and diagnosis are processes in which all plausible hypotheses are formulated and then rigorously investigated to see which one best fits the data. In any case involving the negligent or intentional infliction of psychological distress, there are at least four logical possibilities to explain the plaintiff's symptomatic presentation:

- the symptoms are bone fide and are directly related to the alleged traumatic events
- the symptoms are present but exaggerated
- The symptoms are falsely imputed to the alleged traumatic incident. That is, a patient has genuine

symptoms, but they may have existed before the alleged incident and are now being attributed to the incident which is the basis of the lawsuit.

- the symptoms are malingered

Differing evaluations

In a forensic evaluation, the mental health professional who performs the assessment examines each possible explanation for the patient's symptomatic presentation. Data is collected and each hypothesis is weighed in the light of supportive and disconfirming data. None of the possibilities should be given precedence in the initial stages of the process. At some point, the evaluator forms an opinion and uses the data to support his or her formulation in court.

When psychotherapist testimony is used to establish the presence of psychological injury, the circumstances are very different. In virtually every case, the patient presents his or her history and symptoms to the therapist, who generally accepts the account at face value. No attempt is made to test or disconfirm the implicit hypothesis that the patient's account of events is accurate. The basis of successful psychotherapy is a trusting relationship between therapist and client. Since any attempt by a therapist to verify or disconfirm the patient's version of events would probably destroy this trust, treating therapists rarely attempt to assess the possibility of false imputation or malingering.

Psychotherapy becomes a stealth evaluation when the therapist's impressions of the client's mental state and the proximate cause for these symptoms are presented in

court as though they constituted a forensic evaluation. This type of testimony has a certain logic or face validity that can appeal to a jury that may assume the treating therapist knows the patient well and is in a position to understand the case. The difference between an evaluation and psychotherapy may be difficult to explain to a jury of laymen.

Helpful strategies

There are several strategies which may prove helpful in dealing with this problem. One is to become familiar with the ethical standards and guidelines for psychologists which govern forensic activities. Section 7.02(a) of the Ethical Principles of Psychologists and Code of Conduct states that, "Psychologists' forensic assessments, recommendations and reports are based on information and techniques (including personal interviews of the individual where appropriate) sufficient to provide appropriate substantiation for their findings." This means that treating therapists who testify that their clients have been traumatized by defendants' alleged actions or negligence may actually be acting unethically if they have not made efforts to corroborate the stories, substantiate the existence of symptoms, or rule out symptom exaggeration, malingering and false imputation.

Additionally, section 7.02(b) states that, "Except as noted in (c), below, psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions." Finally, section 7.02(c) states that "When, after reasonable efforts, such an examination

is not feasible, psychologists clarify the impact of their limited information of the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions and recommendations."

It should be noted that this last admonition appears to impose an affirmative obligation on the psychologist testifying in these cases. When the only source of data has been the patient's self-report and the therapist's observations during therapy sessions, it is not enough to respond honestly to questions about methodology. The therapist must make the limitations of his or her data clear by prefacing any remarks with a statement such as: "Let me say before I begin that I am basing my conclusions entirely on my patient's version of the events and description of symptoms. I made no attempt to assess the veracity of this version of the events, nor did I attempt to rule out malingering or symptom exaggeration." Failure to do this may be unethical.

Share research with judges, jury

It is probably also a good idea to educate the judge and jury about the techniques available for the assessment of these issues. There is a substantial body of empirical research devoted to these types of assessments. While these studies are sometimes contradictory, it is clear that there are protocols, procedures and tests which can – and should – be employed in psychological injury assessments. These techniques are rarely used by treating therapists. Making it clear that these techniques are readily available, but were not utilized, can further undermine any

unwarranted conclusions put forward in the therapist's testimony.

Finally, many confident psychotherapists will attempt to brush these concerns aside and claim that their experience and clinical judgment make it possible for them to draw diagnostic conclusions that are reliable and valid. In these cases it is important to be familiar with the extensive literature on the lack of reliability of clinical judgment. There is a great deal of empirical evidence which makes it clear that clinical judgment is notoriously unreliable, particularly when malingering and deception may be involved.

Of particular interest is research that makes it clear that individuals generally thought to have the ability to detect lying and deception, such as psychologists, psychiatrists, judges and police officers, are no better than anyone else at spotting deception. Particularly surprising is the fact that the confidence they attribute to their judgments about deception has no relation to the correctness of these judgments.

Counteracting testimony

Making this information available to the judge or jury in a case can go a long way toward counteracting unsubstantiated therapist testimony. It has been my experience that most attorneys, judges and, regrettably, most psychologists, are unaware of the implications of the ethical standards and guidelines governing forensic activities for psychologists. However, these guidelines are logical, and they help to counter the seemingly logical position that the psychotherapist is in the best position to understand and

testify about the existence and extent of a patient's symptoms.

One of the best ways to develop an appropriate cross-examination or deposition of the treating therapist is to obtain the services of an appropriately trained forensic psychologist to consult on the case, give rebuttal testimony, or both. The issues involved in these types of evaluations are certainly understandable to attorneys, but the ethical and methodological questions raised can be confusing and arcane. The assistance of an appropriately trained and experienced forensic psychologist can frequently be invaluable in countering "stealth evaluation" testimony.

Lying for Patients

Physician Deception of Third-Party Payers

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Background: Some physicians may resort to deception to secure third-party payer approval for patient procedures. Related physician attitudes, including willingness to use deception, are not well understood.

Objective: To determine physician willingness to deceive a third-party payer and physician attitudes toward deception of third-party payers.

Methods: A cross-sectional mailed survey was used to evaluate physician willingness to use deception in 6 vignettes of varying clinical severity: coronary bypass surgery, arterial revascularization, intravenous pain medication and nutrition, screening mammography, emergent psychiatric referral, and cosmetic rhinoplasty. We evaluated 169 board-certified internists randomly selected from 4 high- and 4 low-managed care penetration metropolitan markets nationwide for willingness to use deception in each vignette.

Results: Physicians were willing to use deception in the coronary bypass surgery (57.7%), arterial revascularization (56.2%), intravenous pain medication and nutrition (47.5%), screening mammography (34.8%), and emergent psychiatric referral (32.1%) vignettes. There was little willingness to use deception for cosmetic rhinoplasty (2.5%). Rates were highest for physicians practicing in predominantly managed care markets, for clinically severe vignettes, and for physicians spending less time in clinical

practice. Physician ratings of the justifiability of deception varied by perspective and vignette.

Conclusions: Many physicians sanction the use of deception to secure third-party payers' approval of medically indicated care. Such deception may reflect a tension between the traditional ethic of patient advocacy and the new ethic of cost control that restricts patient and physician choice in the use of limited resources.

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IN THE past decade, managed care programs have increased their role in the daily practice of medicine.[1] Physicians have experienced pressure from managed care organizations (MCOs) to reduce utilization and curtail costs. Practice controls such as utilization restraints and preapproval criteria have limited physician autonomy.[2-5] As MCOs impose stricter controls on access to specific medical treatments, physicians are increasingly facing an ethical dilemma – how to reconcile their professional responsibilities as patient advocates with potentially conflicting contractual obligations to third-party payers.

Anecdotal evidence [6-9] suggests that some physicians have chosen to maintain the appearance of compliance while skirting managed care guidelines in order to secure treatment. Such deception, primarily in the form of incorrect or ambiguous documentation, has been called "gaming the system."[10] However, the full extent to which physicians support the deception of third-party payers, particularly for which clinical indications, remains unknown. Furthermore, physicians' attitudes and beliefs about the use of deception are not well characterized. We report the results of a study investigating physicians' attitudes toward the deception of third-party payers, and identify clinical and demographic patterns associated with the sanctioning of deception.

STUDY VIGNETTES

CORONARY BYPASS SURGERY

A 55-year-old woman presents to a colleague as a new patient seeking referral for coronary revascularization (coronary artery by-pass graft [CABG]). She is homebound because of angina. A recent angiogram indicated severe 3-vessel coronary occlusion that appeared amendable to CABG. However, she was recently forced to switch insurance companies. She remains stable but is receiving a maximal medical regimen. She reports occasional severe angina symptoms relieved by sublingual nitroglycerin administration, but there has been no progression in her chest pain symptoms. Based on a medical literature review, your colleague understands that CABG is medically indicated for such a debilitating and life-threatening condition, yet knows that the patient's third-party payer will not pay for CABG for this preexisting condition unless she has progressive chest pain. Thus, the patient can forgo

CABG or have it at her own expense. However, your colleague also knows that the third-party payer will pay for coronary revascularization if he or she documents "increased frequency of chest pain" as an indication for coronary revascularization, even though such documentation would not be accurate.

PARTICIPANTS AND METHODS

We developed a survey instrument to assess physicians' attitudes toward the deception of third-party payers as a means of securing patient treatment. Our intent was to present physicians with clinical vignettes that a primary care physician might face in practice, and to evaluate their willingness to sanction the use of deception and their attitudes about deception for each vignette. The survey was distributed to internists in 4 regions of the Untied States. We initially developed 10 vignettes of varying clinical severity and pilot tested the survey instrument among physicians in an internal medicine group at an academic health center. Based on follow-up interviews and analysis of responses, 6 vignettes that covered a range of clinical severity were selected and further refined for the final survey instrument.

Physicians were presented with clinical vignettes in which a colleague was considering deceiving a third-party payer to secure treatment for a patient. The use of questions framed for another agent committing a potentially unethical act is an accepted method for eliciting respondent perceptions.[11] Physicians were informed that for each vignette, (1) the patient is seeking only the specific procedure or referral discussed; (2) the patient cannot afford the procedure or referral on his or her own because of financial

hardship, and no external resources are available; (3) local colleagues are unwilling to provide services unless they are reimbursed; (4) despite diligent efforts by the physician and colleagues, the patient's third-party payer is unwilling to change its reimbursement policy regarding the particular procedure or referral; and (5) the third-party payer checks documentation but does not confirm clinical findings.

To evaluate physician support for the use of deception, we employed a conceptual framework based on casuisty.[12] Casuistic analyses begin with a paradigm case and then modify aspects of the case to determine whether changes in the details of the case modify judgments about the morality of the action. In our analysis, we varied the clinical severity and risks associated with the patient's condition between vignettes. Vignettes ranged from life-threatening (arterial revascularization and coronary bypass graft) to emergent (psychiatric referral), palliative (intravenous pain medication and nutrition), diagnostic (mammography), and cosmetic (rhinoplasty). In each vignette, physicians were asked whether their colleague should deceive the third-party payer. Physicians were then asked how they, their colleagues, and society would rate the physician's deceptive behavior on a 5-point Likert scale ranging from 1 (clearly justified) to 5 (clearly unjustified) (see "Study vignettes" section).

Respondents also provided demographic data, practice characteristics, and career and professional perceptions. Demographic data included physician age, sex, and race or ethnic affiliation. Practice characteristics included years since completion of residency, years practicing in the current metropolitan market, percentage of time devoted to direct clinical care, payer mix (percentage of patients

enrolled in Medicare, enrolled in Medicaid, capitated, self-pay, or uninsured), type of clinical income (salaried or nonsalaried), and type of practice setting (academic health center, staff health maintenance organization [HMO], solo practice, or group practice with number of associates). Career and professional perception items evaluated agreement with statements concerning satisfaction with a medical career, opportunity to practice quality medical care, professional autonomy, business aspects of practice, and relationships with colleagues.[13] Physicians were also asked to select 1 of 5 statements characterizing their primary professional responsibility.

STUDY SAMPLE

To determine what role practicing in a predominantly managed care market might have on physician attitudes, we identified 4 metropolitan markets in the Untied States with a high level of managed care penetration. We defined a high-managed care penetration market as a market in which 40% or more of the total metropolitan area population was enrolled in an HMO. Results of prior research[14] have shown that HMO penetrations greater than 30% result in a significant HMO effect on provider and purchaser communities – affecting product diversity, premiums, provider reimbursement, and most important, health system organization. We also identified a low-managed care penetration market in each of the same regions, in which less than 25% of the population was enrolled in an HMO. Metropolitan area managed care penetration figures and populations were obtained from the 1995 Interstudy Competitive Edge Regional Market Analysis 6.1 and reflect market data as of July 1, 1995.[14]

From the list of potential candidate metropolitan areas, we identified high- and low-managed care penetration markets in each region that were most similar in population. We then selected the largest such pairing for inclusion in the study. The high-penetration markets selected (and their respective managed care penetrations and study regions) were Boston, Mass (42.1%, Northeast); Miami, Fla (43.6%, South); Minneapolis – St. Paul, Minn (42.0%, Midwest); and San Francisco, Calif (42.1%, West). The low-penetration markets selected (and their respective managed care penetrations and study regions) were Pittsburgh, Pa (24.2%, Northeast); Atlanta, Ga (16.1%, South); St. Louis, Mo (22.7%), Midwest); and Las Vegas, Nev (20.9%, West). Sample physicians were divided among these 8 metropolitan markets, based on the size of the local population.

We further modified our sample to assess sex effects by quota sampling within each metropolitan region to provide maximal power for sex comparisons. The vignettes were presented to half of the sample in order of increasing clinical severity, and in reverse order to the other half to test for order effects. We limited our sample to physicians exclusively board certified in internal medicine. Physicians were randomly drawn from metropolitan market listings in the 1996 American Board of Medical Specialties Directory of Board Certified Medical Specialists.[15] Physicians who had board certifications in fields other than internal medicine, had completed subspecialty fellowship training (with the exception of general medicine fellowships), or were no longer active in clinical practice were excluded from analysis and replaced with a randomly selected physician of the same sex from the same metropolitan market.

Sample physicians were initially contacted by mailed questionnaire in December 1996. Physicians with incorrect addresses were followed up by local directory assistance where possible. After the start of the study, nonresponders were followed up by 2 additional survey mailings at 1 and 3 months, 2 follow-up telephone calls at 2 and 4 months, and a facsimile transmission of the survey instrument at 6 weeks. All surveys were identified by a unique identification code to ensure confidentiality of responses. Study protocol, methods, and survey instrument were approved by Georgetown University Medical Center's institutional review board, Washington, DC.

DATA ANALYSIS

The primary outcome of interest was physicians' sanctioning of a colleague's deception of the third-party payer in each of the 6 vignettes. The effect of clinical severity on the sanctioning of deception was evaluated by the Cochran Q test and McNemar tests of deception rates in each vignette. We also tested for an association between support for deception and other variables – demographics, practice characteristics, and perceptions of career and professional responsibilities. Physician's reported personal, collegial, and societal justifications of deception in each vignette (reported on a 1- to 5-point Likert scale) were evaluated by a 3 (personal, collegial, and societal perspectives) X 6 (vignette) repeated-measures analysis of variance. A significant interaction effect was followed up using tests of simple effects by the Tukey Honestly Significant Difference test for paired differences. Perceived primary professional responsibility and career satisfaction items are also reported. Categorical variables were compared with the X^2 test and expressed in proportions.

Continuous variables were compared using an independent sample *t* test analysis. Statistical analysis was performed with 2 software packages (SAS 6.11; SAS Institute Inc, Cary, NC, and Statistica; StatSoft Inc, Tulsa, Okla).

ARTERIAL REVASCULARIZATION

A 55-year-old woman presents to a colleague as a new patient seeking referral for arterial bypass grafting for chronic arterial insufficiency to her foot. She has never smoked but has chronic, arterial insufficiency secondary to chronic atherosclerotic disease. She is in pain "at rest," and has chronic nonhealing ulcers. Physical examination reveals pregangrenous skin changes that the patient reports existed before her current insurance coverage began. Based on a medical literature review, your colleague understands that arterial revascularization is medically indicated to avoid later amputation of the toes or foot. Your colleague knows that the patient's third-party payer will not pay for arterial revascularization if the pregangrenous changes were a preexisting condition, which leaves her to forgo the arterial revascularization or have the procedure at her own expense. However, your colleague also knows that the third-party payer will pay for arterial revascularization if he or she documents "new skin changes: pregangrenous" as an indication for arterial revascularization, even though such documentation is inaccurate.

INTRAVENOUS PAIN MEDICATION AND NUTRITION

A 55-year-old woman presents to a colleague as a new patient seeking referral for intravenous pain medication

and nutrition as part of her comfort care at home. She has been diagnosed with incurable ovarian cancer, and is not expected to live long. She has chronic abdominal pain that is relieved only by taking oral pain medication. She also has severe, refractory nausea for 1 to 2 hours after swallowing solids or liquids. All antinausea drugs have failed to provide any relief. She reports no vomiting and no problems swallowing. Based on a medical literature review, your colleague understands that intravenous pain medication and nutrition are medically indicated as part of comfort care for a patient with such a terminal condition, yet knows that the patient's third-party payer will not pay for comfort care as long as she is still able to swallow solids and liquids without vomiting, leaving her to forgo intravenous treatment (and continue taking oral medication and nutrition), or receive it at her own expense. However, your colleague also knows the the third-party payer will pay for intravenous pain medication and nutrition as part of comfort care if he or she documents "recurrent vomiting" as the indication for intravenous pain medication and nutrition, even though such documentation would not be accurate.

PSYCHIATRIC REFERRAL

A 55-year-old woman presents to a colleague as a new patient seeking referral for psychiatric treatment for depression. She notes that the physician who was caring for her died unexpectedly, and that she has been unable to get further information or referrals through his office. She claims a recurrent history of profound depression and cites several past suicide attempts, revealing well-healed scars down both writs. She presents her prescription medication

bottles and claims compliance with a maximal antidepressant therapy regimen for more than 3 months. She reports a 3-week history of daily feelings of profound sadness, guilt, and worthlessness. She has had no interest in regular activities, great difficult concentrating, and feels completely estranged from her family. In addition, she reports fatigue, insomnia, little appetite, and a 15% loss in body weight during the past 3 weeks. She is tearful, agitated, and concerned that she is feeling worse with each passing day. She strongly denies suicidal or homicidal ideation. She is cooperative and even willing to be hospitalized – but only if her insurance will cover the costs. Based on a medical literature review, your colleague understands that urgent psychiatric referral is medically indicated, yet knows that the patient's third-party payer will not pay for psychiatric referral unless she states an intent or exhibits demonstrable evidence of imminent suicidal or homicidal behavior. However, your colleague also knows that the third-party payer will pay for a psychiatric referral if he or she documents "patient states suicidal ideation" as an indication for the psychiatric referral, although such documentation would not be accurate.

MAMMOGRAPH SCREENING

A 55-year-old woman presents to a colleague as a new patient seeking referral for a mammogram. Her younger sister was recently diagnosed with breast cancer. The patient has never had a mammogram but is concerned that she too may have breast cancer. She has not noted any new breast lumps, skin changes, or nipple discharge. Your colleague's physical examination reveals no evidence

of any breast lumps or lesions. Based on a medical literature review, your colleague understands that an annual screening mammogram is medically indicated for women older than 50 years, especially if they have a family history of breast cancer. Your colleague knows that the patient's third-party payer will not pay for a screening mammogram, leaving the patient to forgo screening or have it at her own expense. However, your colleague also knows that the third-party payer will pay for a mammogram if he or she documents "suspicious breast lump" as an indication for the mammogram, even though such documentation would not be accurate.

COSMETIC RHINOPLASTY

A 55-year-old woman presents to a colleague as a new patient seeking referral for rhinoplasty (the surgical alteration of nasal bones). She has no significant medical history and currently has no medical complaints. However, she is sad about feeling less attractive with each passing year. In addition, she becomes tearful when recounting how she has been teased throughout her life about having a prominent nose. She is realistic in not expecting changes in her nose to radically change her life, but she would like to improve this one feature of her body. She denies any injury to her nose and reports no problems breathing. Based on a medical literature review, your colleague understands that rhinoplasty is not medically indicated but would certainly make the patient feel better about herself. Your colleague knows that the patient's third-party payer will not pay for rhinoplasty as an elective procedure, leaving the patient to forgo the procedure or have it at her own expense. However, your colleague

also knows that the third-party payer will pay for rhinoplasty if he or she documents "deviated septum, problems breathing" as an indication for the surgery, even though such documentation would not be accurate.

RESULTS

Of 602 randomly selected physicians, we obtained accurate contact information for 471. A further 18 physicians were excluded because of retirement from practice or having moved out of the sample area, and they could not be replaced by random sampling. At the conclusion of data collection in June 1997, we received 169 responses (37.3% of contacted physicians). Respondents and nonrespondents did not differ by sex, age, or years in practice.

Respondents were predominantly women (52.7%) and white (81.7%), with a mean age of 41.6 years. Most respondents were salaried (78.1%) and located in high-managed care penetration markets (56.85%). A total of 40.8% practiced at academic medical centers. On average, respondents spent 69.4% of their time in clinical work, had been in practice 10.1 years after residency, and had spent 9.3 years in their current metropolitan market (**Table 1**).

Table 1. Physician (N = 169) Demographics

Demographic	Physicians
Women, %	52.7
Age, mean, y	41.6
White, %	81.7
Practice characteristics	
Clinical time, mean, %	69.4
Practice after residency, mean, y	10.1
Practice in current metropolitan market, mean, y	9.3
Salaried, %	78.1
Practice setting, %	
Academic health center	40.8
Staff health maintenance organization	8.3
Solo practice	10.1
Group practice	37.3
Study region, %	
Northeast	33.2
South	20.7
Midwest	30.6
West	15.4
High–managed care penetration	56.8

SANCTIONING DECEPTION

Our principal analysis was a determination of physician support for deception of a third-party payer to secure patient treatment (**Table 2**). Most physicians sanctioned deception to obtain authorization for coronary bypass surgery (57.5%) and arterial revascularization (56.2%). Many physicians also approved deception to obtain intravenous pain medication and nutrition (47.5%), mammography (34.8%), and psychiatric referral (32.1%). Few physicians supported deception for cosmetic rhinoplasty (2.5%). More than a quarter of physicians (26.6%) did not support deception in any vignette, whereas 13.6% sanctioned deception in all vignettes except cosmetic rhinoplasty.

Sanctioning of deception was associated with clinical severity of vignettes (Cochran Q = 200.25; $P<.001$). McNemar tests indicated that sanctioning of deception decreased as clinical severity decreased (Table 2). In other words, the deception rates for each vignette are arranged in descending order as follows: (coronary artery bypass ~ arterial revascularization) > intravenous pain medication and nutrition > (psychiatric referral ~ mammography) > cosmetic rhinoplasty.

Analysis of deception by practice location identified significant variation. Physicians practicing in high-managed care penetration markets were more likely to sanction deception in arterial revascularization (64.1% vs 45.7%; $P = .02$) and mammography (44.1% vs 22.5%; $P = .004$) vignettes. These physicians also provided higher rates of deception approval for all other vignettes, including cosmetic rhinoplasty, although differences were not statistically significant (psychiatric referral, $P = .10$; intravenous pain medication and nutrition, $P = .18$; CABG, $P = .28$; and cosmetic rhinoplasty, $P = .008$).

Physicians who sanctioned deception spent less time in clinical practice than those who did not. In the arterial revascularization vignette, physicians sanctioning deception reported spending 64.8% of their time in clinical practice compared with 75.4% who did not (P = .04). Percentage of clinical time was also lower for physicians who sanctioned deception in intravenous pain medication and nutrition (61.5% vs 78.0%; P = .001), psychiatric referral (61.1% vs 74.2%; P = .02), and mammography (57.8% vs. 76.5%; $P < .001$) vignettes. Clinical experience, as evaluated by years in practice after residency, was not associated with deception in 5 of 6 vignettes; physicians suggesting deception for psychiatric referral had been in practice significantly longer (13.4 vs 8.5 years; P = .02). Practice setting was not associated with sanctioning of deception in 5 of 6 vignettes; physicians practicing at academic health centers trended toward greater sanctioning of deception in the mammography vignette (42.6% vs 28.6%; P = .06).

Sanctioning of deception was not associated with physician sex in any vignette. Physician race and age were also not associated with sanctioning of deception, although both trended toward significance in the mammography (P = .05) and psychiatric referral ($P < .06$) vignettes. Analysis of demographic differences in rates of deception, however, were limited because of low statistical power. In addition, the order of vignettes was not associated with differences in deception attitudes. Because of the low proportion of physicians sanctioning deception in the cosmetic rhinoplasty vignette, we could not evaluate demographic or practice effects for this case. Comparisons of deception sanctioning by demographic and practice characteristics are provided in **Table 3** and **Table 4**

Table 2. Physician Deception and Deception Ratings by Vignette

	Vignette					
	Coronary Bypass Surgery	Arterial Revascularization	Intravenous Pain Medication and Nutrition	Psychiatric Referral	Mammography	Cosmetic Rhinoplasty
Deception rate*	57.7[a]	56.2[a]	47.5[b]	32.1[c]	34.8[c]	2.5[d]
Justifiability of deception ratings†						
Self	2.4[e]	2.4[e]	2.7[e]	3.0[e]	3.1[e]	4.3[e]
Colleagues	2.3[e]	2.3[e,f]	2.5[e]	2.8[e,f]	2.7[f]	3.8[f]
Society	2.2[e]	2.2[f]	2.2[f]	2.7[f]	2.6[f]	3.8[f]

**Vignettes with different superscript letters have significantly different ($P<.05$) deception rates: (coronary artery bypass ≈ arterial revascularization) > intravenous pain medication and nutrition > (psychiatric referral ≈ mammography) > cosmetic rhinoplasty.*

†Mean justifiability ratings within each vignette with different superscript letters are significantly different from each other ($P<.05$). Support for deception is evaluated using a 5-point Likert scale ranging from 1 (clearly justified) to 3 (neither justified nor unjustified) to 5 (clearly unjustified).

JUSTIFIABILITY OF DECEPTION

Physicians rated the use of deception as most justified for a patient requiring coronary bypass surgery and arterial revascularization, and least justified for a patient requesting cosmetic rhinoplasty. A repeated-measures analysis of variance of the justificability of deception ratings indicated a significant interaction between clinical vignette and perspective ($F_{10,1510} = 5.64$; $P < .001$). Analysis of simple effects showed several patterns. First, there were significant differences in physicians' reported justifiability ratings from the 3 perspectives for 5 clinical vignettes. In only the coronary artery bypass vignette did respondents believe that they, colleagues, and society would agree on the justificability of deception. Second, physicians consistently assumed that society would provide greater justification ratings than they would. Third, physicians assumed that they and colleagues would provide comparable justifiability ratings for the 4 more severe vignettes. Physicians were somewhat less tolerant of a deceptive act than they believed their colleagues might be for the mammography and cosmetic rhinoplasty vignettes. Finally, differences between physicians' reported colleague and society justifications were found only in the intravenous pain medication and nutrition vignette. Justification ratings for deception were comparable in all other vignettes.

Ratings of the justifiability of deception paralleled variations in the sanctioning of deception associated with managed care markets. Physicians practicing in high-penetration markets reported significantly greater acceptance of deception than those practicing in low-penetration markets in the arterial revascularization vignette (2.2 vs 2.7; $P < .05$). Greater physician justification of deception in high-penetration markets was also reported in the

coronary bypass graft (2.2 vs 2.6), psychiatric referral (2.8 vs 3.2), and mammography (2.8 vs 3.4) vignettes ($P < .05$ for all).

The high rates of sanctioning of deception were consonant with physicians' reported professional obligations. Most physicians (76.4%) believed their primary professional responsibility was to practice as their "patient's advocate; working within the rules and restrictions of third-party payers, so long as those rules do not significantly compromise my patient's interests." Physicians reporting patient advocacy as a primary responsibility were more likely to sanction deception for arterial revascularization (62.1% vs 25.0%; $P = .001$), coronary bypass (63.2% vs 29.2%; $P = .02$), intravenous pain medication and nutrition (53.7% vs 23.1%; $P = .005$), and mammography (37.1% vs 24.8%; $P = .03$). Physicians sanctioning deception in the psychiatric referral vignette reported significantly greater dissatisfaction ($P = .002$) with their degree of professional autonomy; dissatisfaction with professional autonomy was not associated with sanctioning of deception in other vignettes. Sanctioning of deceptive behavior was unrelated to other measures of career satisfaction. Professional responsibility and career perceptions are reported in **Table 5**.

Table 3. Sanctioning of Deception by Demographics and Practice Characteristics*

	Coronary Bypass Surgery	Arterial Revascularization	Intravenous Pain Medication and Nutrition	Psychiatric Referral	Mammography
HMO market penetration, %					
High	61.3	64.1	52.2	37.4	44.1
Low	52.9	45.7	41.4	25.4	22.5
P	.28	.02	.18	.10	.004
Sex, %					
Male	55.8	54.6	46.7	36.4	36.4
Female	59.3	57.6	48.2	28.2	33.3
P	.66	.69	.84	.27	.68
Race, %					
White	54.9	53.3	45.0	32.6	31.3
Minority	70.0	56.8	58.6	30.0	50.0
P	.13	.73	.18	.78	.052
Practice location, %					
Academic center	58.8	57.4	54.6	31.8	42.6
Elsewhere	57.8	55.6	42.7	33.0	28.6
P	.9	.82	.14	.88	.06
Income, %					
Salaried	57.0	56.2	46.8	29.7	35.7
Nonsalaried	58.1	53.3	44.8	43.3	26.7
P	.92	.77	.85	.15	.35

**HMO indicates health maintenance organization.*

Table 4. Sanctioning of Deception by Practice Characteristics and Demographics*

	Deception		
	Sanctioned	Did Not Sanction	P<
Coronary artery bypass graft			
Age, y	41.6	41.2	.80
Clinical time, %	66.8	73.5	.20
Years in practice	9.9	10.3	.83
Years in sampled market	8.9	9.9	.47
Arterial revascularization			
Age, y	41.4	41.6	.93
Clinical time, %	64.8	75.4	.04
Years in practice	9.9	10.4	.79
Years in sampled market	8.9	9.8	.49
Intravenous pain medication and nutrition			
Age, y	41.1	41.6	.75
Clinical time, %	61.5	78.0	.001
Years in practice	9.7	10.1	.77
Years in sampled market	8.8	9.7	.52
Psychiatric referral			
Age, y	43.7	40.3	.06
Clinical time, %	61.1	74.2	.02
Years in practice	13.4	8.5	.006
Years in sampled market	10.9	8.6	.11
Mammography			
Age, y	41.0	41.4	.79
Clinical time, %	57.8	76.5	.001
Years in practice	9.5	10.1	.76
Years in sampled market	8.4	9.6	.42

** Years in sampled market refers to number of years practicing in current city.*

COMMENT

In this study, many physicians sanctioned the use of deception to obtain medical care for a patient when denied authorization by a third-party payer. Sanctioning of deception varied by the clinical severity of a patient's condition, but deception was sanctioned by most physicians in our 2 most clinically severe vignettes. Physicians also reported high levels of justification for the deception of third-party payers. Because most physicians report that it is their duty to work as patient advocates within the rules of third-party payers until those rules compromise their patients' care, this underlying attitude may represent physicians' main justification for sanctioning deception and the view that deception is justifiable.

Although physician support for deception was high in the overall cohort, we noted significant variations between locations. Physicians practicing in high-managed care penetration markets were more likely to sanction deception than were those in other markets. Although only significant in 2 scenarious, physicians in high-penetration markets trended toward higher rates of deception in all clinical vignettes. A similar pattern was observed for physician ratings of the justifiability of deception, which were also higher in high-penetration HMO markets. Taken together, these data suggest that HMO market penetration affects physicians' willingness to sanction the use of deception. This finding is consistent with the hypothesis that, as managed care brings more restrictions to a market, physicians practicing in that market become more willing to support deception as a means of circumventing these restrictions.

We hypothesized that deception rates would be highest in vignettes of greatest clinical severity and immediate patient risk. The relative ranking of physician sanctioning of deception in the vignettes supports this hypothesis. Furthermore, physicians showed greater support for deception in life-threatening illness than in urgent care needs, and in cases of palliative and diagnostic care than in cosmetic care.

Table 5. Professional Responsibility and Career Perceptions

Statement	Agreement, %
Primary professional responsibility*	
Practice within the rules/restrictions of third-party payers with strict adherence to those rules to the best of my ability	4.3
Practice within the rules/restrictions of third-party payers as long as those rules do not significantly compromise my patients' interests	8.7
Practice in a way that equally balances my patients' interests with the rules/restrictions of third-party payers	8.7
Practice as my patients' advocate working within the rules/restrictions of third-party payers as long as those rules do not significantly compromise my patients' interests	74.5
Practice as my patients' advocate without regard to the rules/restrictions of third-party payers	3.7
Career perceptions	
I doubt that medicine is the right profession for me	21.1
My opportunity to practice quality medicine falls short of my expectations	32.7
My degree of professional autonomy falls short of my expectations	46.3
The business aspects of my practice are worse than I expected	50.6
My relationships with my colleagues are worse than I expected	0

**Categories of primary professional responsibility, as indicated by participants.*

Previous studies have documented physician willingness to use deception to secure medically indicated patient care. A survey[16] of physicians practicing in the North-east found that nearly 70% of respondents would knowingly misdocument a screening test as a diagnostic service to ensure coverage of service. Primary care physicians have historically misdocumented diagnoses to reduce the risk of patient stigmatization or insurance and employment discrimination.[17] However, results of recent studies[18] show that patient concerns about maintaining insurance coverage and ensuring continued access to care through service reimbursement have become more frequent reasons for deliberate miscoding. Similar uses of inaccurate documentation to secure patient care have been reported by other health care professionals.[19] In fact, an evaluation[20] of ethical dilemmas in outpatient practice identified patient cost considerations as the primary source of ethical problems arising from office visits.

The advent of managed care and increased reliance on utilization review has further restricted a physician's ability to practice independently, increasing patient and physician frustration.[21] These effects are logically felt most in markets where managed care has the greatest effect on health care delivery. Our data suggest that physicians in such markets are more willing to respond to managed care's restrictions by condoning deception. Physician deception in these markets might not even be limited to life-threatening vignettes but also used in other cases in which a physician believes a procedure is in the patient's best medical interests. This sentiment can reach extremes. That physicians who condoned deception to secure coverage for cosmetic rhinoplasty – the survey's only medically nonindicated vignette – were exclusively from high-managed care

penetration markets underscores the extent of this sentiment. Resistance to such practices may also explain physicians' unwillingness to cooperate with third-party payers in other areas, including disclosure of patient information[22] and suspected patient health insurance fraud.[23]

Both MCOs and professional societies are aware of this trend in physician behavior.[10,23-27] Managed care firms have responded to inaccurate claims by increasing the rigor of utilization review and terminating contracts with physicians suspected of using deception. Professional societies have standing guidelines that prohibit fraudulent misrepresentation in dealings with insurers. However, these guidelines are not fully developed. The American College of Physicians' Ethics Manual[25] states that physicians are not obligated to lie to a third-party payer for a patient, but it does not expressly condemn deception to obtain care. The American Medical Association's Council on Ethical and Judicial Affairs[26] and the Woodstock Theological Center[27] specifically enjoin physicians from using deception or gaming the system and instead, urge physicians to work through appeals processes at MCOs. Although President Clinton's recently announced *Patient Bill of Rignts* and similar Congressional efforts[28,29] might facilitate such appeals, patients' expectations of their physicians, coupled with MCOs' fundamental reliance on decreased use of services to reduce costs, suggests continued conflict and only minimal gains.

Although many physicians believed deception was appropriate in the face of restrictions on patient care, a large proportion also refused to sanction deception. More than a quarter did not recommend deception in any study vignette. Written comments of some respondents indicated

that they would try to secure coverage and overturn previous service denials by discussing the vignette patient's situation with the third-party payer, despite the study vignettes' instructions otherwise. Although these physicians may be successful in their appeals, their acceptance of restrictions on medically indicated treatment has significant implications for patient care. Furthermore, current case law holds that physicians who are willing to accept an MCO's limits on provision of care have no immunity from civil liability related to the withholding of care.[30] Respondents who feel strongly compelled to follow contractual rules might be surprised to find that compliance with MCO rules does not decrease their exposure to malpractice or legal obligation to patients.[31] In contrast, the smaller group of physicians who sanction deception in all medically indicated vignettes (cosmetic rhinoplasty excluded) support the equally troubling conclusion that some physicians view deception as an acceptable method of dealing with third-party payer limitations. Acceptance and deception, rather than advocacy, set dangerous precedents for future practice for both the physician involved and the profession.

Despite the nature of our findings, deception is not new to medical practice. Physicians have been known to advocate deception in several situations: lying when they believe it will benefit a patient,[32] choosing not to inform terminally ill patients of their true diagnosis,[33] and intentionally miscoding to protect patient confidentiality[17] or to secure reimbursement for treatment.[6] In more spurious cases, physicians have also used deception for personal benefit, as a means of disguising malpractice, for career advancement, or to defraud payers.[34-36] Hospitals have also been implicated for deceptive practices in dealing with

third-party payers, from subtle "diagnosis related group creep"[37] to more extreme cases of Medicare fraud.[38] However, until recently, deception was unrelated to access to care. Physicians were historically able to treat uninsured patients and those with limited access to care by distributing treatment costs across the remainder of their paying practice.[39] As cost shifting and other methods of providing unreimbursed care have disappeared under managed care, so have the avenues by which physicians can treat patients who lack coverage for specific services.

Our study has some limitations. Although physicians indicated a significant willingness to sanction deception, we are unsure of the extent to which such willingness translates into the actual use of deception in practice. Are physicians as willing to deceive in practice when faced with the possibility of civil or criminal sanctions? Conversely, does the frequent process of attempting to secure patient care and repeated frustration further embolden a physician? What are the implications of recent legislative and judicial attempts to address this issue? Although we cannot be certain, we believe our data indicate that physicians, at a minimum, accept and are willing to use deception as a means of responding to third-party payer restrictions. In addition, our relatively low response rate limited our availability to evaluate effects such as practice in a staff model HMO, patient payer mix, and physician demographics.

In conclusion, the practice of medicine now extends beyond the patient-physician relationship. Physicians and patients are contractually bound to third-party payers and their rules. On occasion, such obligations conflict with physicians' obligations to act as patient advocates. Although using deception to solve these impasses may

succeed in the interim, their long-term costs in loss of integrity and increased practice oversight are high. Situations that produce deception can ultimately only be solved by direct confrontation and frank dialogue between physicians, patients, and payers. Alternatives to deception include broadening existing appeals processes on behalf of individual patients and political advocacy for health care reform. Refusal to initiate a social dialogue regarding the appropriate balance between medical and economic considerations places medicine at risk of becoming a practice of equal parts patient care and subterfuge.

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Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems

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To assess physicians' attitudes toward the use of deception in medicine, we sent a questionnaire to 407 practicing physicians. The questionnaire asked for response to difficult ethical problems potentially resolvable by deception and asked general questions about attitudes and practices. Two hundred eleven (52%) of the physicians responded. The majority indicated a willingness to misrepresent a screening test as a diagnostic test to secure an insurance payment and to allow the wife of a patient with gonorrhea to be misled about her husband's diagnosis if that were believed necessary to ensure her treatment and preserve a marriage. One third indicated they would offer incomplete or misleading information to a patient's family if a mistake led to a patient's death. Very few physicians would deceive a mother to avoid revealing an adolescent daughter's pregnancy. When forced to make difficult ethical choices, most physicians indicated some willingness to engage in forms of deception. They appear to justify their decision in terms of the consequences and to place a higher value on their patients' welfare and keeping patients' confidences than truth telling for its own sake.

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PHYSICIANS face many ethical problems in medical practice in which truth telling may appear problematic.[1] In deciding what information to convey to patients, families, and third parties, conflicts often arise between competing values, and one must be chosen over the other. Sometimes physicians judge the use of deception to be the most therapeutic and morally justifiable alternative. Although ethical issues related to truth telling have been well discussed,[2-5] there are no generally accepted guidelines to help physicians in making these difficult decisions. The American Medical Association's "Principles of Medical Ethics" enjoins physicians to "deal honestly with patients and colleagues" without offering specifications.[6] The recent *American College of Physicians Ethics Manual* advises

physicians to act "with sensitivity and without duplicity" when forced to serve conflicting interests,[7] but it does not discuss deception as a separate issue or emphasize truth telling as an overriding moral imperative.

What are physicians' attitudes toward the use of deception to resolve ethical problems in medical practice? How do they reason when considering how much to tell or whether to tell the truth in various situations? These are important questions since physicians' decisions to use deception have implications for patient trust and the quality of their physician-patient relationships. The aggregate of their decisions has implications for public regard of the medical profession. There is only limited information regarding these questions. Physicians' attitudes toward disclosure have been studied in surveys regarding telling cancer patients their diagnoses[8,9] and regarding informed consent.[10-12] To our knowledge, no previous study has addressed deception as a separate issue. To assess physicians' attitudes and stated practices regarding the use of deception, we sent a mail survey to practicing physicians, which explored the following questions: Would physicians say they would choose to use deception under certain circumstances? If so, how would they justify its use? Do physicians' approaches to deception vary according to such factors as age, sex, and specialty?

METHODS

A questionnaire presented four ethical problems in patient care that could potentially be resolved by the use of deception. Case descriptions were followed by multiple-choice options for resolving the problems and a list of possible justifications for the option chosen. Finally, general questions were asked about principles and attitudes toward deception. In the first phase of the study, we sent the questionnaire to 78 residents in internal medicine at a major medical center. Sixty-three (81%) of the residents responded. Analysis of these results led to minor revisions of the questionnaire. We then sent the questionnaire to a sample of 407 practicing physicians randomly selected from a health department's list of 2350 licensed physicians in a state in the Northeast. The sample consisted of 98 general practitioners, 105 surgeons, 106 obstetrician-gynecologists, and 98 internists. Two mailings and one follow-up telephone reminder led to 211 returned questionnaires, a 52% response.

Response distribution of each action and respondents' first justification was computed. Age, specialty, self-rated use of deception, and attitudes toward the use of deception were compared with case-management choices and justifications, using the x^2 statistic. Eleven questionnaires were omitted from statistical analysis because of unanswered or improperly answered questions, although these surveys were reviewed for their written comments.

The mean age of respondents was 49 years, with the following distribution by age categories: ages 20 to 29 years, 6%; 30 to 39 years, 25%; 40 to 49 years, 19%; 50 to 59 years, 22%; and 60 years and older, 28%. The internists were somewhat younger as a group, with a mean age of 43

years, while the mean ages of the obstetrician-gynecologists, general practitioners, and surgeons were between 50 and 51 years. The respondents were 25% internists, 25% obstetrician-gynecologists, 26% general surgeons, 21% general practitioners, and 5% others (these and other figures may exceed 100% because of rounding).

RESULTS

Case vignettes and questions are presented as they appeared in the questionnaire. Physician choices of action and first justifications for action are depicted in Figs 1 through 4. Justifications chosen by fewer than 5% of respondents were consigned to the other or unspecified category.

Case 1

You are seeing Mrs Lewis, a 52-year-old patient of yours, for her annual physical, which reveals no abnormalities. You tell her that everything looks normal and that you are going to order routine blood tests and her annual screening mammography, which you feel is important for women of her age. She is against the mammography, saying that the last time you ordered it, she had to pay for it herself. You know she is of modest means and cannot easily afford it. You are surprised that her health insurance did not cover it. Upon asking your secretary, you learn that the insurance covers the cost of mammography only if there is a breast mass or objective clinical evidence of the possibility of cancer. The secretary tells you that the way to get around this is to put down "rule out cancer" instead of "screening mammography" on the form.

1. How would you fill out the form?

   a. Rule out cancer

   b. Screening mammography

2. If you chose (*a*) to question #1 was it because (choose one, or rank your choices):

   a. You think the insurance company's distinctions are unreasonable.

   b. You feel a stronger obligation to your patient than to the insurance company.

   c. You feel everyone else does it.

   d. You feel the financial hardship on Mrs Lewis would be greater than on the insurance company

   e. Other (please explain).

3. Again, if you chose (*a*) to question #1, do you feel you deceived the insurance company? (Y/N)

4. If you chose (*b*) to question #1, was it because (choose one, or rank your choices):

   a. You think the insurance company's distinctions are reasonable.

   b. It is wrong to deceive a 3rd party for a patient's benefit.

   c. You are worried about the legal/professional liability involved.

   d. You feel such practices are responsible for increased health care costs.

e. Other (please explain).

Choices of action and justification are depicted in Fig 1. Choices 2 *c* and 4 *c* above were not chosen and are thus not depicted. In addition, in response to question 3, 112 (85%) of 132 physicians said they did not believe they deceived the insurance company by choosing "rule out cancer."

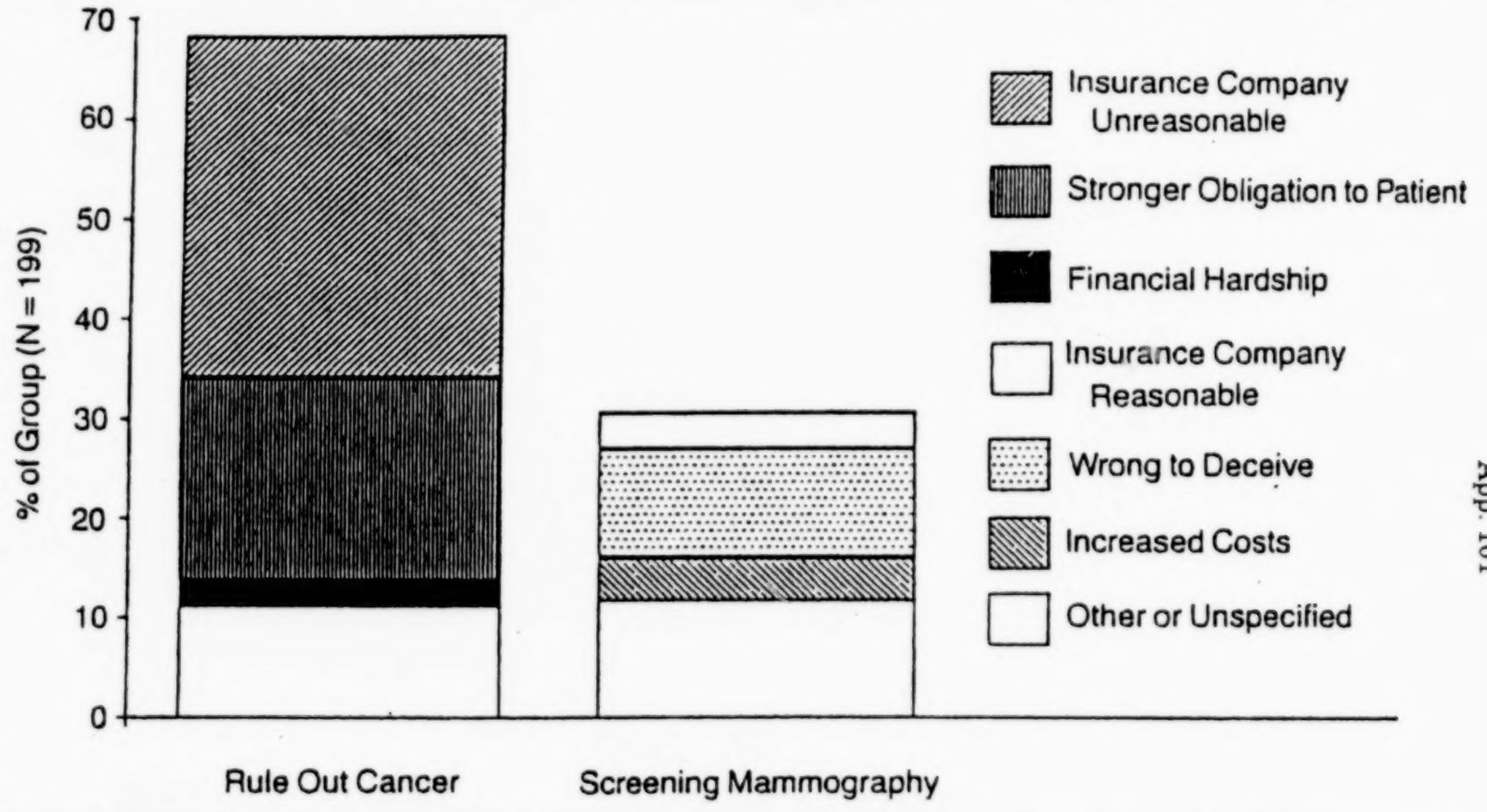

Fig 1.—Case 1. Filling out insurance form.

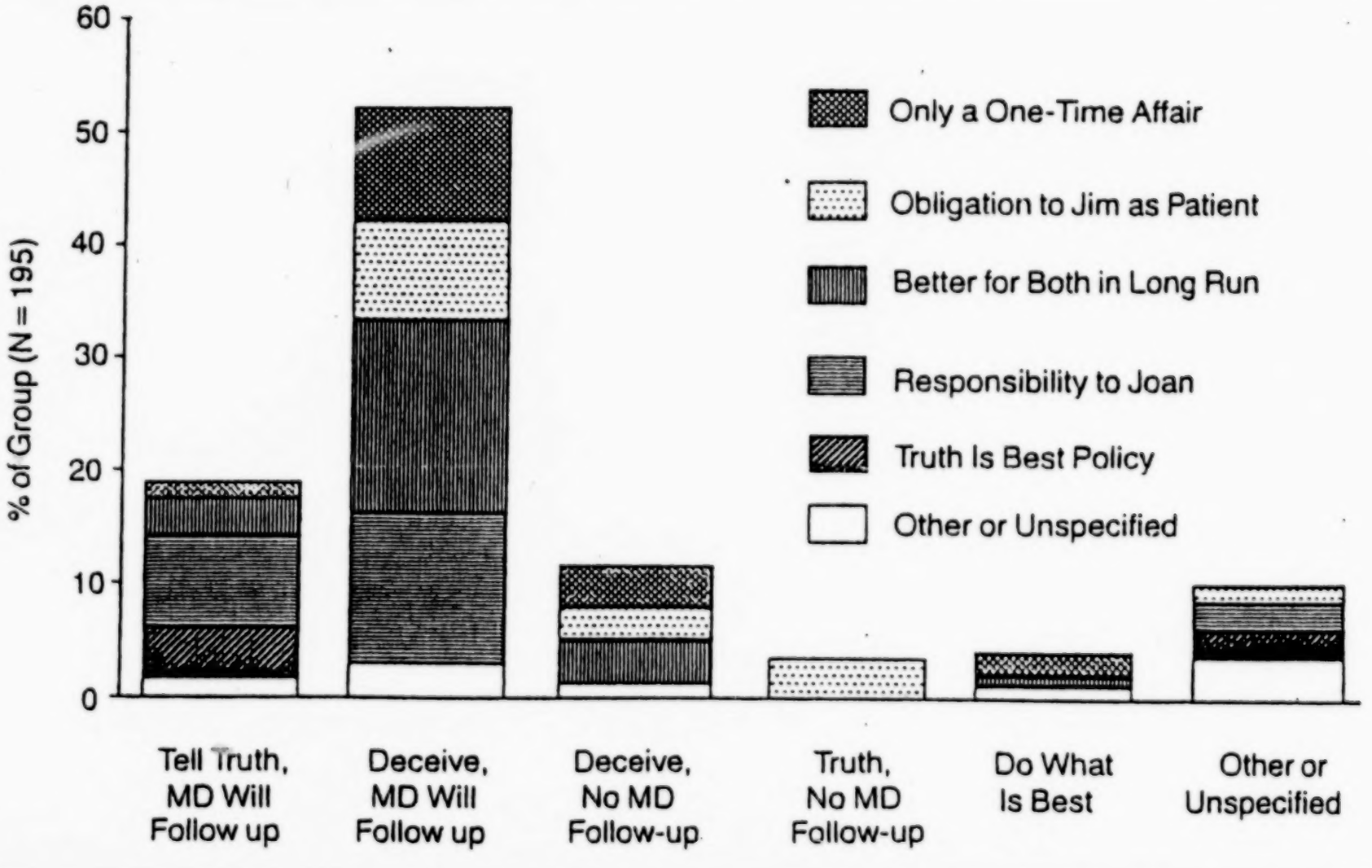

Fig 2.—Case 2. Tell wife about gonorrhea.

Case 2

Jim Wentworth is a 43-year-old married businessman who has been your patient for many years. You are surprised that he comes to see you with complaints of dysuria and purulent urethral discharge. Microscopic exam of the discharge reveals gonorrhea. You tell Jim that the test confirms that he has gonorrhea, and you administer penicillin. You explain that state law requires you to report cases of gonorrhea to the Health Department and that his wife, who is not your patient, must be treated since she has been exposed.

Jim begs you not to report his disease, "I know exactly where I got this," he explains, "I picked up a prostitute a couple of weeks ago when I was at a convention. If you tell Joan, she'll walk out on me. And if you report me to the Health Department, they might call Joan. I swear, I've never done anything like this before. Please don't ruin my marriage by telling Joan!"

After a lengthy conversation, Jim remains adamant about not telling Joan, and you are convinced the marriage would be in jeopardy if she found out.

5. Would you (choose one):

a. Insist that Jim tell Joan he has gonorrhea and bring her in for treatment. If this is not done within 48 hours, you will contact her and tell her yourself.

b. Agree to have Jim tell his wife that it is a nonspecific urethritis, but insist she be treated. If this is not done within 48 hours, you will contact her and tell her to get treated.

c. Agree to have Jim tell his wife that it is a nonspecific urethritis and give him enough tetracycline to treat his wife.

d. Tell Jim he must tell Joan he has gonorrhea, but do not follow up yourself.

e. Tell Jim to tell Joan what he thinks best.

f. Other (please explain).

6. In choosing your answer, what was/were your prime considerations? (choose one, or rank order):

a. You don't believe a one-time affair warrants the break up of a marriage.

b. Since Jim is your patient, your obligation is to treat him and respect his privacy in deciding how Joan will be treated.

c. You feel the majority of your colleagues would do the same.

d. You feel it would be better in the long run for both Jim and Joan.

e. You feel you have a responsibility to Joan as well.

f. You feel truthfulness is the best policy.

g. You feel you have an obligation to society.

h. Other (please explain).

Choices of action and justifications are depicted in Fig 2. Physicians were also asked if they would report this case to the health department. Seventy-eight percent indicated that they would. We further asked why they chose to do so. Twenty-five percent chose the option, "your legal

obligation outweighs the risk of Joan being informed," 30% chose "your obligation to society outweighs the risk Joan might be informed," and 34% chose "you would ask the Health Department not to call Joan."

Case 3

Sherry Jacobs, a 15-year-old young woman, comes to your office complaining of nausea and vomiting. Her mother is along. You know them well, as you have been treating the family for 10 years. When the mother leaves, you learn Sherry has been sexually active for the past year. A pregnancy is positively confirmed and estimated at about 10 weeks.

Sherry immediately speaks of abortion, and says she plans to go to a neighboring state where this can be done without her parent's knowledge. (State law prohibits abortions for minors without a parent's consent.) She begs you not to tell her parents. You know they would attempt to prevent the abortion if they knew and much family tension would result. Yet, if the parents found out later it might destroy the relationship you have built with them. You urge Sherry to share the news with her parents and discuss options with them. She remains adamant.

9. When Sherry's mom returns and asks your diagnosis, you tell her (choose one):

a. Sherry is pregnant and offer your support and availability as a counselor.

b. I've talked this over with Sherry and she can talk with you about it.

c. Sherry's symptoms are due to something common that's going around.

d. Sherry has a gastroenteritis, which should clear up in a week or so.

e. Other (please explain).

10. In choosing your answer, what was/were your prime considerations? (choose one, or rank order)

a. You were guided by your moral view on abortion.

b. You did not want to violate doctor-patient confidentiality.

c. You believe Sherry's mother has a right to know.

d. You believe Sherry is too young to make this decision on her own.

e. You believe this is best for Sherry.

f. You are concerned about your relationship with the family.

g. Other (please explain).

Choices of action and justifications are depicted in Fig 3.

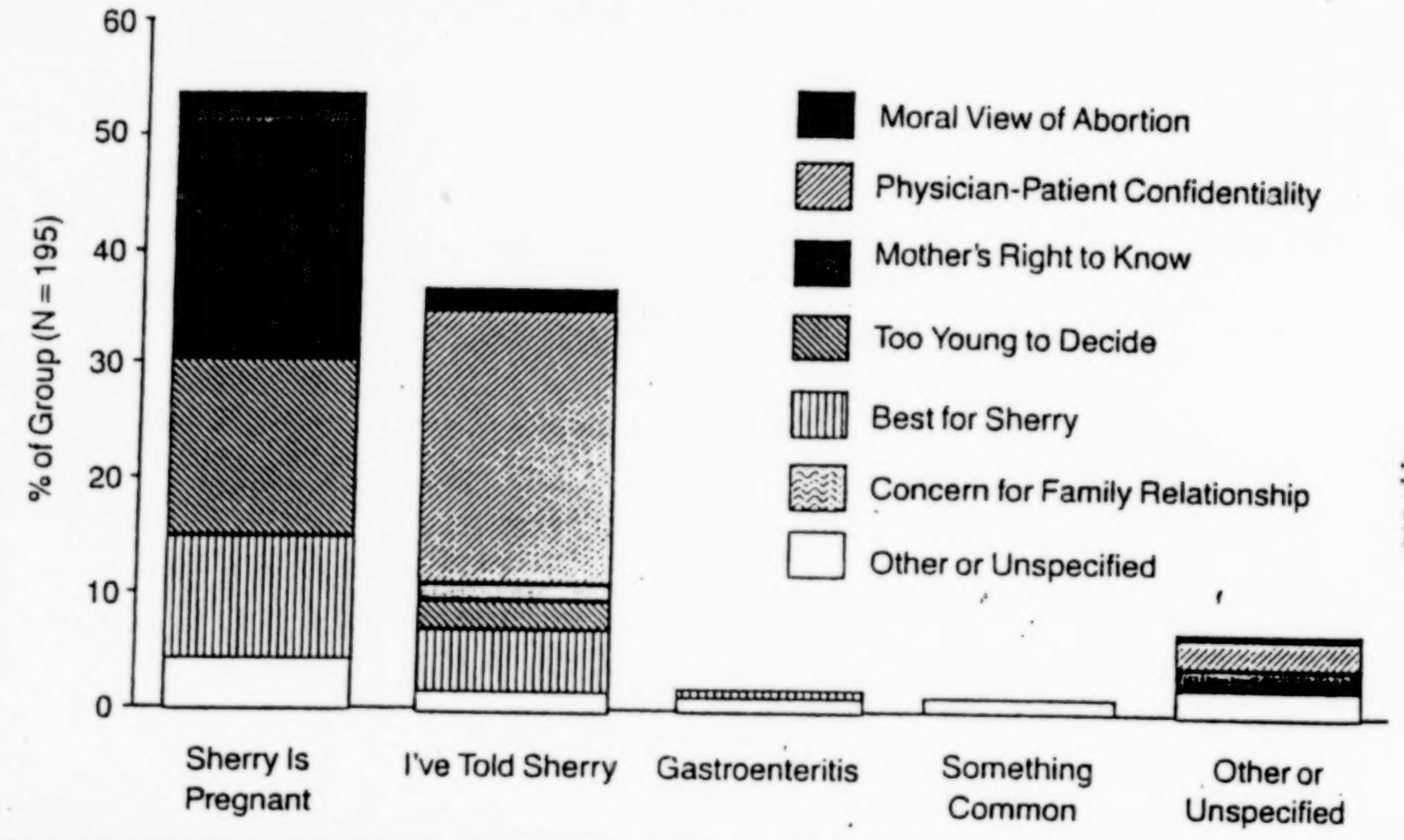

Fig 3.—Case 3. Pregnant teenager.

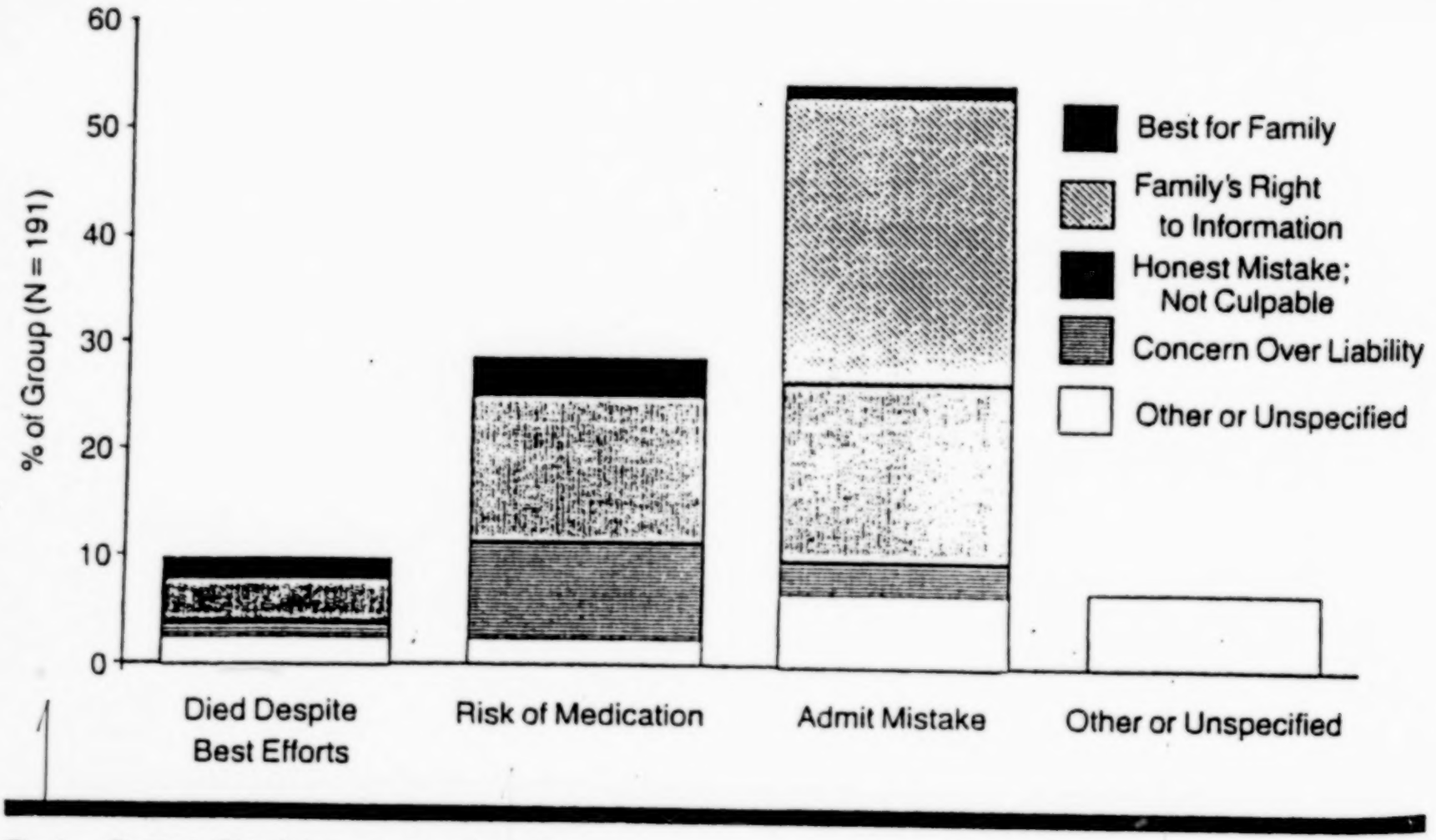

Fig 4.—Case 4. Physician error; patient dies.

Case 4

An 80-year-old man with severe hypertension comes into the hospital with confusion, papilledema, and a blood pressure of 250/150 mm Hg (hypertensive crisis). Having decided to start him on diazoxide, you administer a vial labeled with the usual dose of 100 mg. Shortly thereafter, the patient's blood pressure drops and despite resuscitative efforts, he dies. In reviewing his medications, you find that the vial actually contained 1000 mg of a "100-mg/cc" solution. You are thus sure you accidentally administered a fatal dose.

11. When informing the family about the patient's death, you would (choose one):

a. Emphasize that the patient was very sick but despite your best efforts, he died.

b. Emphasize the patient was very sick and required strong medication. As an unfortunate, but known risk of the medication, his blood pressure dropped too low and he died.

c. Say you inadvertently gave him too much medication over too short a time, which given his serious condition probably caused his death.

d. Other (please explain).

12. In choosing your answer, on what did you base your decision? (choose one, or rank order)

a. What was best for the family.

b. The family's right to full information.

c. Your belief that you made an honest mistake and are not culpable.

d. Your concern about legal/professional liability.

e. Other (please explain).

Choices of action and justifications are depicted in Fig 4.

Among the four cases, choices of deceptive alternatives (1, *a*; 5, *b*; and *c*; 9, *c* and *d*; and 11, *a* and *b*) were statistically independent (by x^2 test); that is, a physician's choice in any one case was not predictive of that physician's choice in any of the other three cases.

Questions Regarding Principles

Physicians were asked in an open-ended manner to describe their basic principles regarding the use of deception to benefit their patients. One hundred nine (54%) of 202 physicians described their principles. Forty-eight (44%) of 109 physicians made explicit statements about the importance of truthfulness. Fourteen (13%) of 109 physicians asserted that physicians should never deceive. However, 95 (87%) of 109 physicians indicated that deception is acceptable on rare occasions, giving a variety of reasons: if the patient would be harmed by knowing the truth, to circumvent "ridiculous rules," and to protect confidentiality. A comment that was typical of this group was: "I try to take everything on a case by case basis and to tailor my actions to the people and the situation I confront. . . . The only basic policy is first do no harm. Honesty is *usually* the best policy."

Forty (37%) of 109 physicians stated their principles in terms of deceiving patients. Of these, the majority stressed the general importance of honesty, but stated that shaping the truth (ie, being overly optimistic or using less threatening terms) is, on occasion, necessary.

Eighteen of those 40 physicians volunteered that nondisclosure is sometimes necessary when full disclosure would harm a patient.

We asked physicians to rank the factors they consider when justifying decisions to use deception for their patients. Their replies are presented in Table 1. Note that 31 of 60 respondents not answering this question stated in response to a later question that they never use deception with patients.

Questions Regarding Attitudes and Practices

We next asked physicians questions that elicited attitudes and estimated the frequency of the use of deception by patients, society at large, other physicians, and themselves. The majority believed that their patients did not expect them to use deception and that they never or rarely use deception with patients. They perceived deception to be more common among their patients, other physicians, and society at large (Table 2).

Table 1.—First and Second Justifications for the Use of Deception

Rank the Top 4 Factors You Consider When Justifying Your Decision to Use Deception for Your Patient	% Choosing Justifications		
	First (n = 140)	Second (n = 116)	Total
The benefits (for the patient) outweigh the potential costs or harm	71	13	84
The value of the patient's privacy and confidentiality	9	35	44
Possible harm to others that may be at risk	2	30	32
Moral convictions regarding deception	14	12	26
Possible legal ramifications	1	7	8
Obligation to society	2	3	5

Table 2.—Responses to Attitude Questions

	% of Respondents (n = 193)			
	Strongly Agree	Agree	Disagree	Strongly Disagree
"My patients expect me to utilize deception for their benefit."	2	25	38	35
"If I were a patient, I would expect my physician to utilize deception on my behalf."	3	23	36	38
	Never	Rarely	Occasionally	Often
"How often do you feel your patients intentionally deceive you?"	2	22	66	11
"How often do you feel deception is used in society at large (ie, by politicians, salesmen, lawyers, in advertising, etc)?"	0	1	13	87
"How often do you feel deception is utilized by physicians?"	1	26	59	15
"How often do you utilize deception with patients?"	25	55	18	1

Effects of Attitudes and Stated Practices on Answers to Cases

There was little relationship between physicians' answers to the case questions and their stated general attitudes toward the use of deception. Those who said they "never" use deception, when compared with those choosing "rarely," "occasionally," or "often," were less likely ($P<.02$) to choose deceptive answers in cases 1 and 2. In case 4, this difference approached statistical significance ($P=.05$). Still, of the 49 physicians who asserted that they "never" deceive, 26 (53%) chose "rule out cancer" in case 1, twenty-four (49%) chose to allow Jim to mislead Joan about his diagnosis in case 2, and 16 (33%) chose to misinform the family about their mistake in case 4.

Effects of Sex, Age, and Specialty on Choices

There were too few women in our sample to determine differences in responses by gender. There were two differences by age category. In case 2, there was a stepwise increase by age category in the percentage of physicians who would inform Sherry's mother about the pregnancy: ages 20 to 29 years, 2 (18%) of 11; ages 30 to 39 years, 20 (42%) of 48; ages 40 to 49 years, 20 (54%) of 37; ages 50 to 59 years, 24 (60%) of 40; and ages 60 years or older, 37 (70%) of 53. In case 4, physicians over 50 years of age were less likely to tell the family of their mistake (45/92 [49%] would tell) than those under 50 years of age (60/90 [67%] would tell) ($P<.03$, Yates' Corrected x^2).

There was one notable specialty difference: obstetrician-gynecologists were clearly different from other physician categories in case 3. Twenty-seven (63%) of 43 physicians would withhold information about Sherry's

pregnancy from her mother, while 54 (39%) of 140 physicians of other groups would do so ($P<.002$). Obstetrician-gynecologists were more than twice as likely than others (20/44 [46%] vs 30/135 [22%]) to cite respect for confidentiality as their justification ($P<.05$).

COMMENT

Does deception have a place in ethical medical practice? If deception is sometimes warranted, how do physicians reason when considering its use? If physicians' attitudes toward the first question do not match patient expectations, patient trust in individual physicians and in the profession as a whole may be diminished. Because decisions to deceive are often difficult, the answer to the second question could shed light on physicians' core values concerning medical practice. This preliminary survey suggests that the majority of our physician-respondents are willing to use deception in at least some situations when confronted by conflicting moral values. They evaluate the consequences of their decisions and appear to place a higher value on their patients' welfare and keeping patients' confidences than on truth telling for its own sake.

Physician's decisions regarding deceptive behaviors must be based on their understanding of what constitutes deception. To deceive is to make another believe what is not true, to mislead.[13] However, physicians' comments on our survey suggests that they have different personal definitions of deception. Some believe that they never or rarely deceive: one physician wrote, "No good doctor 'deceives'! Perhaps better terms might be: consideration, expression, compassion, . . . support, tailor management to patients' needs." Others believe that they frequently

deceive: "Deception . . . every time we say 'you'll feel a pinch' for a lidocaine injection or 'this won't hurt' for a bone marrow. . . . In an effort to be kindly and helpful and positive we *frequently* deceive our patients as to our true thoughts at various times." Others may at times confuse the truth with truthfulness, perhaps not recognizing that true statements can sometimes mislead. For example, some who chose "rule out cancer" in case 1 wrote, "I *am* ruling out cancer," a true statement that is nevertheless deceptive to the insurance company.

There are many forms of deception. One can actively deceive by lying, equivocating, and using vague speech. One can passively deceive by nondisclosure, by allowing another to deceive, or by failing to correct a misconception. Physicians may have differing attitudes about the relative acceptability of the different forms of deception. As in euthanasia, the passive forms of deception may be regarded as less wrong than the active forms. It could be, for example, that in case 2, physicians more readily chose to participate in the deception of Jim's wife because it was Jim who was doing the initial deceiving. We did not specifically investigate comparative attitudes toward different forms of deception. This would be an important area for further study.

In physician-patient encounters, it may be useful to further discuss decisions to deceive in terms of two distinct issues: who is being deceived and who will benefit from the deception. For example, physicians may deceive patients, patients' families, insurance carriers, and themselves. One or more of these parties may benefit from the deception. Thus, many combinations are seen. A physician may deceive a patient with cancer to avoid psychological distress in the patient and family members. An insurance

carrier may be deceived to secure payment for a needed test, benefiting the patient and the physician. Physicians may benefit from self-deception, as in believing that it is too uncomfortable for dying patients to discuss end-of-life issues, when it is really too uncomfortable for themselves.

There has been some previous work regarding physicians who deceive patients about their diagnoses. One of us (D.H.N) and colleagues,[8] studying physicians' attitudes toward "telling" the cancer patient, found that 98% of respondents reported a general policy of disclosure. Physicians reported making exceptions to that policy on rare occasions, based on considerations of age, intelligence, emotional stability, and a relative's wish about telling the patient. Although lying to patients may be abjured, the use of vague speech and non-disclosure of information may be somewhat more common in practice.[14,15] In one study, 20% of neurologists favored withholding anxiety-provoking information from adult patients with seizure disorders and their families.[10] In another, vague information about diagnosis and treatment was given to 39% of 1262 women with newly diagnosed breast cancer.[16] Case law from various states provides that physicians have discretion in determining which hazards of contemplated procedures should be revealed to patients.[17] Disclosure practices merit further study and reassessment in light of findings that patients report a preference for far more detailed disclosure than physicians routinely offer.[10] There are few documented harmful effects of disclosure[9] and many proved benefits.[9,18]

Our data suggest that deceiving a third party to benefit patients may be quite acceptable to physicians in some situations and less so in others. Most of our respondents were willing to misrepresent a screening test as a

diagnostic test to ensure payment. This raises the possibility that offering "creative diagnoses" to thirty-party payers may be a widespread practice. In case 2, the majority of physicians were willing to participate in a deception of Jim's wife. However, in case 3, few were willing to lie to Sherry's mother. The factors that may contribute to these different attitudes, such as differences in the magnitude and forms of the required deception, the proximity of the parties deceived, and differing justifications for deception should be the subject of further investigation.

This study suggests that physicians may commonly engage in self-deception, which may facilitate other forms of deception. In case 1, the majority of both groups who chose "rule out cancer" said that they were not deceiving the insurance company, even though the case example was designed to make it clear that they were. Even the 25% of physicians who said they "never" use deception often chose deceptive answers to our case examples. One example is a physician who wrote many comments affirming the physician's duty to tell the truth. He stated that he "never" used deception with patients and indeed chose "screening mammography," "insist that Jim tell Joan he has gonorrhea . . . , and "Sherry is pregnant." However, in case 4 he chose, "emphasize that the patient was very sick but despite your best efforts, he died." He explained, "Narrowly phrased, this *is* the *truth* isn't it – the 'best efforts' of your practice were *your best* – stupid – but 'the best' for you!"

Our survey suggests that under extreme circumstances, some physicians would consider deceiving to benefit themselves. In case 4, more than a third of physicians said they would provide incomplete or misleading information to a family about a mistake that led to a

patient's death. While many argued in their comments that the family would only be further hurt by the knowledge of the mistake, deception clearly offered benefits to the physicians as well. While some case law suggests a legal duty to disclose mistakes to patients or their families, there is no uniform legal code that demands such disclosure.[17,19] The codes of medical ethics do not discuss this issue.[6,7]

In making their decisions to deceive, the majority generally appeared to adopt a consequentialist approach. That is, they appealed to the good consequences produced and the bad consequences avoided by deception. This finding is consistent with a review of ethical positions adopted by writers on ethical issues of cancer.[20] The great majority of physician-respondents indicated an overriding concern for their patient's welfare and indicated that they would deceive if necessary to protect that welfare. This was evidenced by the two most commonly stated justifications for deception: the benefits outweigh the costs and the protection of a patient's confidences. Only after these patient-centered justifications were others mentioned: concern for possible harm to specific others who may be at risk, and, much less frequently, moral convictions about deception, concern for legal ramifications, and obligation to society.

It is clear from their written comments that our respondents are dedicated and thoughtful physicians who make difficult decisions at difficult times. Overall, they indicated a respect for truth telling. In a society where they perceived deception to be quite common, they believed that they used deception far less than the norm. They seemed to agree with Brody's[21] conclusions about truth telling: "We cannot agree with criteria that elevate

the truth as a fundamental moral value for its own sake, independent of the effect that the truth will have on the individual. . . . The fundamental value at issue is that of respect for persons. Truth is valuable because in the vast majority of cases, respect for truth is a way of demonstrating respect for persons; but in rare instances respect for persons might demand that the truth be given a lower priority compared to other considerations."

Still, this study raises a number of questions about physicians' attitudes and practices. Are the attitudes revealed by this survey consistent with physicians' and patients' ideals for ethical medical practice? The physicians' overriding concern with patient welfare, consistent with Hippocratic tradition, gives less consideration to questions about the potential harm to others of deceiving. What if Joan, thinking nonspecific urethritis is a minor infection, stops taking the tetracycline and gets pelvic inflammatory disease? What about the others in the insurance pool whose physicians won't write "rule out cancer"? What harm may deception do to the physician's self-image and to the patient's trust? What harm may ensue if the policy of deceiving in certain circumstances becomes more general, and how will that affect public trust in the profession? Although patient advocacy is a cherished medical tradition, its role in decision making may need to be reassessed and weighted against other considerations.

These data have implications for policy, teaching, and future research. In case 1, our respondents seemed to be saying that health insurance carriers should restructure their policies toward covering more preventive health care. Failure to do so may be perpetuating a system that gives an advantage to those patients whose physicians disregard

guidelines in filling out forms. For teachers of medical ethics, these data may stimulate discussions about priorities among conflicting moral imperatives. It would be useful to have more discussions about physician deception to others to benefit patients or to prevent recognition of a mistake. A recent presentation of basic curricular goals in medical ethics does not mention these issues.[22] The study questionnaire and others like it may be useful as teaching tools. Specific cases are effective in illustrating abstract ethical principles, and the specific and general questions force students to make choices that can stimulate them to examine their values.

This study must be considered exploratory. Its response rate and limited scope preclude generalizations about the prevalence and nature of physician deception. Further empirical research is clearly indicated, focusing not only on physicians but also on patients and other professional groups. Do other professional groups have similar standards regarding the use of deception? What do patients think their physicians' behavior should be? What are the nuances of physician reasoning in justifying deception? How do they think about the ethical issues of patient autonomy, beneficence, and justice? To what extent and how do they weigh benefits and risks? How do attitudes toward patient care affect choices (eg, are physicians with more paternalistic attitudes more likely to consider some forms of deception acceptable)? It would be useful to interview physicians to more fully understand the subtleties of their decision making. In addition, some actual practices, such as furnishing "creative diagnosis" to insurance carriers, could be determined.

While further empirical research may help clarify the ethics of deception, normative questions will remain. Is it

ever ethical to deceive? If some deception is ethically acceptable, where should the lines be drawn? How could codes of medical ethics more explicitly address the physician's obligation to be truthful and more clearly define which moral imperatives take precedence in situations of conflict? A better understanding of deception should lead physicians to a clearer articulation of the principles that guide their actions. In the final analysis, questions about physicians' relationship to truthfulness will only be resolved by enlightened debate and, ultimately, by each physician guided by his or her conscience.

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The questionnaire used in this survey is available from the first author.

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PRIVACY

Guarding medical secrets, at a cost

[Picture Omitted In Printing]

Doctors are withholding medical information from health records, and even lying, to help patients protect their privacy. In a new survey of 344 members of the Association of American Physicians and Surgeons, 87 percent reported that patients had asked them to exclude data from their records, and 78 percent had complied. Nearly one fifth admitted to making false entries.

Mark Schiller, a San Francisco Bay area psychiatrist and member of the AAPS board of directors, says that because of privacy concerns, he only takes basic notes about patients' condition and medications. Yet an incomplete or distorted record poses its own risks. He says he unnecessarily prescribed anti-psychotic medications to patients who had not divulged their cocaine or crystal meth habits. "I now have to balance privacy concerns with the need to communicate with other physicians," says Schiller.

– *Dana Hawkins*

AMERICAN MEDICAL ASSOCIATION [LOGO]
Physicians dedicated to the health of America

Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depend upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocates and by fostering these rights:

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as furthef treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate.

(Source: Report of the Council on Ethical and Judicial Affairs of the American Medical Association. Originally adopted June 1990. Updated 1994.)

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JAN

Accommodating Individuals with Back Impairments

Job Accommodation Network
1-800-526-7234 (V/TTY)
http://www.jan.wvu.edu
A service of the Office of Disability Employment Policy
of the U.S. Department of Labor

By John Greer, MS

Preface

It is estimated seventy-five percent of the population will have low back pain at least once. While most individuals with back pain will recover without invasive treatment, some will have to deal with limitations for the rest of their lives. Accommodations for individuals with back impairments help individuals overcome these limitations and help keep them working.

In 1999, the Bureau of Labor Statistics estimated nearly half of on-the-job injuries involving time away from work were caused by back injuries. Of these, 19.1% of the workers were out for 31 days or more. Employers involved in proactive workers' compensation case management focus on early return-to-work; with the use of accommodations, a win-win situation for employer and employee can result. Employers may also have to consider accommodations for employees injured off the job under the Americans with Disabilities Act (ADA). Employer responsibilities vary under the ADA but often effective accommodations enable employees with back impairments to perform job functions.

When considering accommodations for people with back impairments, the accommodation process must be conducted on a case-by-case basis. Functional limitations vary from person to person and job to job. When determining effective accommodations, the person's individual abilities and limitations should be considered and problematic job tasks must be identified. Therefore, the person with the back impairment should be involved in the accommodation process. If further information on the responsibilities of an employer and the rights of the individual under the ADA are needed, please feel free to contact JAN.

Not all people with back impairments will need accommodations to perform their jobs and many others may need only a few accommodations. For those who need accommodation, the following pages provide basic information about common limitations, symptoms, useful questions to consider, and accommodation possibilities. The following is only a sample of possibilities to consider; numerous other solutions and considerations may exist.

In addition to accommodation ideas, the following material includes information regarding some of the products available to accommodate people with back impairments. The information represents a sample of the possible products and vendors available. Numerous other products and vendors may exist. Also included in this publication is a list of resources for additional information.

What is back pain?
The spinal column is broken down into five sections: cervical (neck), thoracic, lumbar, sacrum, and coccyx. Ligaments, tendons, and muscles connect to vertebrae to provide structural support for the body. Between the

vertebrae are shock absorbing cushions called discs. Pain can occur when a ligament, tendon, or muscle becomes sprained or strained. Pain can also occur when one or more discs bulge out of designated spaces and put pressure on nerves.

What are the symptoms of back pain?
Symptoms of back pain can be localized or widespread radiating from a central point in the back. Sciatica is pain starting in the lower back and traveling down one or both legs.

What causes back pain?
Back pain may be caused from overuse, acute injury, vertebrae degeneration, nerve impingement, spinal stenosis (narrowing of the spinal canal), infection, and tumors.

Who gets back pain?
It is estimated that 75% of the population will have at least one episode of back pain during a lifespan. Contributing factors to back pain may include poor conditioning, overuse, obesity, cigarette smoking, and age.

How is back pain treated?
Most back injuries are treated with non-invasive treatment techniques. Treatment options include drug therapy, chiropractic adjustments, acupuncture, physical therapy, and rest. In a few cases surgery may need to be performed; some surgery options are vertebrea fusion, discectomy, and laminectomy.

QUESTIONS TO CONSIDER WHEN DETERMINING ACCOMMODATIONS

1. What symptoms or limitations is the individual with back pain experiencing?

2. How do these symptoms or limitations affect the person and the person's job performance?

3. What specific job tasks are problematic as a result of these symptoms and limitations?

4. What accommodations are available to reduce or eliminate these problems?

5. Are all possible resources being used to determine possible accommodations?

6. Has the employee with back pain been consulted regarding possible accommodations?

7. Once accommodations are in place, would it be useful to meet with the person with back pain to evaluate the effectiveness of the accommodations and to determine whether additional accommodations are needed?

8. Do supervisory personnel and employees need training regarding back pain, other disability areas, or the Americans with Disabilities Act?

ACCOMMODATION CONSIDERATIONS FOR PEOPLE WITH BACK IMPAIRMENTS

Activities of Daily Living

- Allow use of a personal attendant at work
- Allow use of a service animal at work
- Make sure the facility is accessible

- Move workstation closer to the restroom
- Allow longer breaks
- Refer to appropriate community services

Fatigue and Weakness

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced

Gross Motor Impairment:

General

- Modify the work-site to make it accessible
- Provide parking close to the work-site
- Provide an accessible entrance
- Install automatic door openers
- Provide an accessible restroom and break room
- Provide an accessible route of travel to other work areas used by the employee
- Modify the workstation to make it accessible

• Make sure materials and equipment are within reach range

• Move workstation close to other work areas and break rooms

Industrial

• Provide overhead structure for lifting devices

• Modify the work area to make it adjustable

• Place frequently used tools and supplies at or near waist height

• Provide low task chairs for work that cannot be brought to waist height

• Provide stand/lean stools and anti-fatigue mats for standing work

• Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required

• Provide compact lifting devices to push and pull supplies and tools from storage

Office

• Provide a height adjustable desk and ergonomic chair

• Move workstation close to common use office equipment

• Provide low task chair and rolling safety ladder to access high and low file drawers and supplies

• Provide a cart to move files, mail, and supplies

• Provide a lazy Susan carousel or desktop organizers to access frequently used materials

Service

• Provide anti-fatigue mats and stand/lean stools for functions requiring long periods of standing

• Provide a height adjustable desk and ergonomic chair

• Move workstation close to commonly used office equipment

• Provide compact lifting devices to push and pull stock and supplies from shelves

• Provide carts to move supplies and stock

Medical

• Provide a spring bottomed linen cart

• Make patient lifting and transfer devices available

• Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required

• Train employees on proper lifting techniques and on proper use of patient lifting and transfer devices

• Provide powered beds for transporting patients

• Provide a height adjustable desk and ergonomic task chairs to fit use for different people

EXAMPLE ACCOMMODATIONS FOR PEOPLE WITH BACK CONDITIONS

A systems administrator with a back impairment is required to move, lift, and carry computers throughout the office. The person was accommodated with a compact, adjustable height lifting device with straps to secure the load.

A maintenance worker with a bending and lifting restriction due to a back injury is required to lift manhole covers. The worker was accommodated with a truck mounted jib crane and manhole cover lifter.

A clerical worker with scoliosis has sitting and standing restrictions. Because the worker is required to work at a desk a majority of the time, the worker was accommodated with an ergonomic workstation evaluation, ergonomic chair, and a sit/stand computer workstation.

A mechanic with a bending restriction due to a low back impairment has problems accessing the engine compartment and law task areas of vehicles. The mechanic was accommodated with a tire lift, a mechanic's low task chair, and a specialty creeper designed to support the body while accessing engine compartments.

A file clerk with a back impairment has functional limitations limiting her ability to bend and access files in low file drawers. An electric automated filing system was purchased to allow accessing of file drawers at a standing height.

A chemical process plant worker is limited in his ability to turn large wheel valves due to a back injury. The worker was accommodated with a specialty tool designed to increase torque on wheel valve handles.

An appliance delivery driver with a lifting restriction due to a low back injury was accommodated with a stair climbing hand truck. This battery-operated piece of equipment also doubles as a lift gate to help lower appliances on and off the truck.

A grocer check-out person with a standing restriction due to a back injury was accommodated with a sit/lean stool and anti-fatigue mats.

A mailroom worker with a push/pull restriction was required to deliver the mail on a cart that weighed more than the individual's push/pull restriction. An accommodation of a motorized cart allowed the person to stay on the job.

A truck driver with a back impairment was limited in the time he could drive. Accommodations of a suspension seat and a vehicle cushion designed to reduce vibrations allowed the driver to comfortably sit for longer periods of time.

A health care worker with a lifting restriction was accommodated with patient transfer devices and individualized training on proper use and selection of the equipment.

PRODUCTS

There are numerous products that can be used to accommodate people with back impairments. JAN's Searchable Online Accommodation Resource at <http://www.jan.wvu.edu/soar> is designed to let users explore various accommodation options. Many product vendor lists are accessible through this system; however, JAN provides these lists and many more that are not available on the Web site upon request. Contact JAN directly if you have specific

accommodation situations, are looking for products, need vendor information, or are seeking a referral.

Sample products include:

Adjustable / Ergonomic Chairs
Compact Lifting Devices
Ergonomic Equipment
Independent Living Aids
Patient Lifting Devices
Sit / Stand Workstations
Stand / Lean Stools
Stair Climbing Hand Trucks
Supine Workstations

Gaming the System

Dodging the Rules, Ruling the Dodgers

E. Haavi Morreim, PhD

•Although traditional obligations of fidelity require physicians to deliver quality care to their patients, including to utilize costly technologies, physicians are steadily losing their accustomed control over the necessary resources. The "economic agents" who own the medical and monetary resources of care now impose a wide array of rules and restrictions in order to contain their costs of operation. However, physicians can still control resources indirectly through "gaming the system," employing tactics such as "fudging" that exploit resource rules' ambiguity and flexibility to bypass the rules while ostensibly honoring them. Physicians may be especially inclined to game the system where resource rules seriously underserve patients' needs, where economic agents seem to be "gaming the patient," with needless obstacles to care, or where others, such as hospitals or even physicians themselves, may be denied needed reimbursements. Though tempting, gaming is morally and medically hazardous. It can harm patients and society, offend honesty, and violate basic principles of contractual and distributive justice. It is also, in fact, usually unnecessary in securing needed resources for patients. More fundamentally, we must reconsider what physicians owe their patients. They owe what is theirs to give: their competence, care and loyalty. In light of medicine's changing economics, two new duties emerge: economic advising, whereby physicians explicitly discuss the economic as well as medical aspects of each treatment option; and economic advocacy, whereby physicians intercede actively on their patients' behalf with the economic agents who control the resources.

(*Arch Intern Med.* 1991; 151; 443-447)

Pauline Stafford had lung cancer. Before surgery, Mrs. Stafford was referred for computed tomography to determine whether the cancer had yet metastasized to her brain. Her insurance did not cover screening procedures, however, and would reject the claim if "rule out brain tumor" were written the space marked "diagnosis." And so the physician directed his office staff to write "brain tumor," even though the test showed she had no tumor. When Pauline subsequently received in the mail a statement of her insurance benefits she saw the entry under "diagnosis" and concluded the worst. Two days later, after preparing her husband's dinner and typing out his daily business agenda, Stafford hanged herself. On the appeal of a $200,000 verdict against the physician and Neurological medicine, Inc, the US Court of Appeals upheld the jury's finding that the erroneous entry on the claim form was the proximate cause of Stafford's suicide and ruled that their financial award to her husband was not excessive.[1]

The case of Pauline Stafford is not only a sad story. It captures one of the most vexing dilemmas of medicine's changing economics: physicians are expected to deliver quality care to their patients, including sometimes to utilize costly technologies, yet they are steadily losing their accustomed control over the necessary medical and monetary resources. No longer will insurers cheerfully pay out large sums, simply on a physician's say-so. However, physicians can still exert considerable indirect influence over resources by "gaming the system," using tactics such as "fudging" that enable one to skirt resource rules while appearing to comply with them. In this paper we will see

how this awkward situation has come about, why "gaming" can be tempting, why it is hazardous, and most importantly, how this predicament forces us fundamentally to reevaluate physicians' obligations to their patients.

PHYSICIANS' OBLIGATIONS, OTHERS' RESOURCES

We can be brief in exploring the origins of the problem, for that groundwork has been laid elsewhere.[2-4] It begins with physicians' obligations of fidelity to their patients. Traditionally, fidelity is necessary because patients are vulnerable. They may have physical, emotional and intellectual infirmities; their usually minimal medical knowledge requires them to trust in the physician's expertise; and treatment often requires them to expose personal intimacies and sometimes to incur substantial risk. Physicians therefore are obligated to be medically competent and to promote the patient's interests, even above their own.[5]

Over the years, medical competence has come to include not only the duty to keep abreast of new information, but to use appropriate technologies, such as x-rays and biopsies.

If physicians, as an aid to diagnosis, ie, judgment, do not avail themselves of the available scientific means and facilities for the collection of the *best* factual data upon which to arrive at the diagnosis, the rest is not an error of judgment but negligence in failing to secure an adequate factual basis on which to support that diagnosis or judgment.[6 (p. 173), 7-9]

Furthermore, in requiring the physician simply to "take the x-rays, or have them taken,"[10] and to keep patients in the hospital as long as is medically necessary (regardless of insurers' reimbursement decisions,"[11] courts have shown little or no interest in who owns the x-ray equipment or hospital bed, or who must pay the staff who tend them. "Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care.[12 (p. 677)] White it is unclear just how far physicans' legal duties to use technologies actually reach (eg, the physican is not required to purchase the patient's prescription medications out of his or her own pocket), the physician is usually well-advised to use whatever technological resources are clearly part of the standard of care.[4]

Morally, it has similarly been routine to believe that physicians in the clinical setting "are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."[13 (p. 1573)] The physician's duty is to the patient, not to society or to insurers.[14-16]

In essence, then, physicians have been expected virtually to commandeer other people's money and property for the benefit of their patients. For many years such economic indifference was plausible. Insurance, both private and government, was structured to insulate patient and provider from worrying about costs.[16] Reimbursement was retrospective and usually generous, and cost-shifting (providers' practice of raising charges to paying patients in order to cover nonpaying patients) covered many of the uninsured who found their way into the health care system.

In reaction to three decades' explosive expansion in health care expenditures, however, the "economic agents" who furnish the medical and monetary resources of care are no longer willing to stand as silent partners funding whatever physician and patient choose to do. Government, business, insurers, institutional providers such as hospitals and health maintenance organizations, and virtually everyone else with a major financial stake in health care now control their resources with a striking array of cost-containment and profit-producing measures, ranging from managed care and intensive utilization review to caps on coverage and restrictions on eligibility. The physician thus finds himself or herself increasingly trapped between traditional mandates to deliver unstinting resources to patients and a progressive loss of the power to do so.[4,17] And if physicians try to avoid this predicament by becoming themselves owners of the relevant resources, they can create formidable conflicts of interest between themselves and their patients.[6]

GAMING: DEFINITION, DEVICES

While physicians have lost much of their direct control over resources, in fact they retain considerable indirect control. Where economic agents' resources rules seem to impede care, the physician can usually find ways to game the system, to bypass those rules while still appearing to honor them and thereby to secure resources that were not, technically at least, intended for this patient.

This room for manipulation has two sources. First, all resource rules leave room for interpretation. They must be articulated with language, and language is inherently vague, as it uses a limited number of verbal concepts to

capture the infinite variety of experience. Reimbursement based on diagnosis-related groups, for example, requires the physician to state the patient's diagnosis. Yet, in fact, it is often possible for the physician to describe his patient's condition in a variety of ways. The physician might describe the patient's episode as a "probable transient ischemic attach" or as a "possible stroke," depending on which will yield better reimbursement.[18-19]

Second, resource rules must leave flexibility for individuality of care. Medically, patients and their illnesses are too complex and diverse to be described adequately by any "cook-book" or computer.[2-3] And legally, insurers and hospital administrators who dared to dictate the daily details of care might be accused of practicing medicine without a license[20] or, at least, could increase their own exposure to tort liability." Therefore, they often are willing to accede to the physician who insists that a patient needs some particular intervention,[21] or at least to negotiate some mutually acceptable course of care.[22]

Between the resource rules' unavoidable vagueness and their necessary flexibility then, the creative physician can invent numerous ways to game the system. Not all manipulation of resources rules counts as gaming, of course. When resource rules are substantially ambiguous, the physician might simply select whichever fully correct description of the patient's condition will produce the most favorable application of the resource rules. For a Medicare patient with multiple medical problems, for instance, one can list renal failure rather than diabetes or hypertension as the "principal diagnosis," thereby maximizing the hospital's diagnosis-related group reimbursement.

Gaming does not begin until the physician pushes harder against a proper fit between language and reality. He may fudge, using florid descriptions to exaggerate the seriousness of the patient's condition to a utilization review officer who has been reluctant to authorize hospitalization,[21] or he or she might install an intravenous line in a patient who has no need for intravenous medication, solely to ensure such a utilization review authorization. There are many methods and degrees of fudging, short of outright lying, and many physicians have expressed willingness to resort to such tactics on occasion.[23]

At the extreme, the stretch and push of fudging merges into the flagrant dishonesty of fraud. The plastic surgeon may say that this patient's rhinoplasty was "necessitated" by a (fictitious) ski accident. The internist may file claims for tests that were never performed or for patients who do not exist, or may secure payment several times for a single procedure (*Wall Street Journal* December 6, 1989; A-1, A-8).

Gaming is not only easily available. It is now sorely tempting, because it seems to offer escape from an impossible situation by allowing physicians to secure indirectly what they no longer control directly. The physician still manages to extract the hospital admission or the costlier therapy, despite third parties' refusals or reluctance.

THE CASE FOR GAMING

Gaming is particularly tempting in two kinds of situations. First, many patients lack adequate health care coverage. Almost 40 million Americans have no medical insurance. Where formerly many of these people had at least some gratuitous entry into the health care system,

the disappearance of cost shifting has left many of these people wither in overcrowded hospitals or without care altogether. Beyond this, many insurance policies are not comprehensive. An infant recovering from meningitis may be medially ready to leave the hospital receiving oral antibiotics without, for example, but if his or her 14-year-old, illiterate mother is unlikely to adhere to the necessary outpatient regiment, the physician may want to "find" some further "medical problem" that "requires" a longer inpatient stay. The medical orientation of most insurance rules leaves little room for such medically significant social problems of for the psychosocial component of many medical problem.[24] Similarly, many physicians are disturbed by insurers' traditional refusal to cover screening tests and other important preventive care. Even insurance coverage that is basically adequate can precipitate problems. Many patients, unaccustomed to paying for medical care and now facing higher cost sharing or reduced coverage, may pressure their physicians to waive their copayments of to "get the insurance to pay" for services not covered by their policies or health maintenance organizations plans.

Second, patients do not always receive even the resources to which they are entitled. Some insurers have developed a truly awe-inspiring array of tactics by which to avoid or delay making the payments they owe.[25] In other cases an unsophisticated utilization review clerk may deny approval to reimburse hospitalization for a condition that clearly requires it, as where a patient has a clinically obvious even if atypical presentation of appendicitis. Or in some instances the physician may question the patient's health care policy at a fundamental level. A health maintenance organization may lure subscribers with promises

that "we provide all the care you'll ever need," yet fail to disclose an assortment of coverage limits, incentive systems, and barriers to care.[26-29] Where there is good reason to suspect that the payer is "gaming the patient," the physician may be sorely tempted to dodge its rules.

Note, patients are not the only ones whose needs may be ill-served by resource rules. Hospitals, too, can suffer where payers refuse to pay, or where they must care for too many indigent patients. Likewise, physicians' fees are increasingly the targets of cost containment. We can argue that physicians need to take their own incomes seriously as a moral issue,[30] and that greed can never justify gaming. We may also agree that physicians and hospitals ought to provide at least some uncompensated care for indigent patients, yet we must acknowledge that these obligations are not unlimited. It is unfair to expect providers alone to make up for the broader society's lack of a comprehensive health care system.

THE CASE AGAINST GAMING

Though gaming can be powerfully attractive in a system that leaves many patients with inadequate health care resources, and that still expects physicians generously to deliver resources that they no longer fully control, it also carries formidable moral and medical hazards. It can violate principles of nonmaleficence, veracity and justice.

Nonmaleficence is the principle of avoiding harm. Gaming can harm the very patient it is intended to help, as sadly evidenced by the case of Pauline Stafford. Even if we argue that the immediate harm to Stafford could have been avoided if the physican had explained his 'creative

accounting' system ahead of time, an important indirect harm could thereby be done to her trust for him. If he is so cheerfully willing to lie for her, perhaps he is equally willing to lie to her. Moreover, such an explanation can place the patient in a very awkward position. One who does not morally approve of such deception must either challenge the physician's integrity outright, or must be an uneasy silent accomplice to the dishonesty. Further, if a physican exaggerates the seriousness of a patient's condition to utilization review officers on the telephone, he or she may have to write those exaggerations in the chart, thus jeopardizing the patient's future care. Similarly, a phychiatrist who identifies a patient's illness according to the most serious, best-reimbursed diagnosis, he may needlessly stigmatize the patient elsewhere in life.

Other patients, too, can be directly harmed. If a physician gains entry for a patient into a crowded coronary intensive care unit by (mis)describing the patient's exertional angina as "unstable," some needier patient may be denied admission. Physicians can even hurt themselves. If an adverse medical outcome happens later to lead to litigation, even altruistically motivated fudging could undermine the physician's credibility in the eyes of a jury.

Everyone can be harmed by gaming. Where physicians routinely game their way around an undesirable resource rule instead of openly challenging it, they may help to perpetuate unwise policies. Thus, if insurers' refusal to cover reasonable screening tests is as medically and economically counterproductive as many physicians believe, surely it is better to challenge this policy than to preserve it by pretending to honor it.

Gaming also offends veracity. Virtually every act of gaming features some duplicity, for by definition gaming is an attempt to bypass resource rules while still appearing to honor them. We need not belabor the importance of honesty. It is a basic tenet of moral integrity, of respect for other persons, and of successful communication and cooperation in a community.[31] Furthermore, no resource system can long survive widespread abuse and dishonesty, nor can physicians expect to retain either their professional integrity or, equally important, their clinical autonomy, if they treat with duplicity those who own the medical and monetary resources essential to their patients' care.[22] While the wrong is blatant where the physician games for personal gain, it is also formidable when done to help the patient.[32] It is therefore, difficult to defend even the marginal duplicity of fudging, and probably impossible ever to justify outright fraud.

Finally, gaming can offend both contractual justice and distributive justice. Contractual justice concerns fair exchange, honest dealing, and keeping one's promises.[2] Here we especially note the contract between patient and payer. The patient, perhaps through his or her employer, has paid a specified amount for a designated, and limited, list of services. Admittedly, the physician plays an important role in this contract. He or she recommends medical services to the patient and often controls the patient's access to them through his power of prescription. The physician even controls the patient's access to third-party reimbursements, as insurers require the physician signature attesting to what was done, and why.

However, this does not entitle the physician to override, undermine or otherwise "correct" the contract between patient and insurer solely because he personally

has judged it to be inadequate. So long as our health care system is based on free enterprise and voluntary negotiation among competent individuals and groups, widespread gaming represents not only an assault on legitimate agreements, but an invitation to economic anarchy. Contractual justice is better served when bad contracts are openly challenged than when they are covertly undermined.

In government insurance, too, recipients' entitlements are created, also with express limits, through a kind of contract among citizens and their legislators. Where policies are unwise or inadequate they should be corrected not by a gaming that undermines both the social decision and the democratic process by which it was made but, rather, through public discussion.

Gaming can also offend distributive justice, the basic fairness with which scarce resources are allocated.[2] Scarcity means that not everyone can have everything that he or she needs. Therefore, even the fairest possible system for distributing health care resources will have unfortunate consequences in individual cases. Gaming is tempting in such cases because, if successful, it can help those individuals to avoid those consequences. Yet, if the overall distribution system is just, these individuals who extract more than their share, even for the worthwhile goal of better health, are unjustly freeloading at others' expense. If scarce resources are to be distributed fairly, all must cooperate.

Even in societies like the United States where the health care distribution system is far from just, distributive justice would still ask the physicians to refrain from gaming to gain extra resources for their own patients.

Gaming, if widespread enough, can destroy any system of resource rules. Unless the distribution system is so seriously unjust it warrants classic civil disobedience or even revolutionary overthrow, it is usually better to preserve order through that system even while one remedies its faults through open political processes.[2,3]

In sum, then, although there are powerful reasons to game resource rules where one's patient seems to be denied a needed or even entitled resource, moral principles of nonmaleficence, veracity and justice would oppose gaming. Fortunately, a better answer is available from two sources: a practical look at the actual mechanics of health care financing, and a moral reexamination of physicians' traditional fidelity obligations to their patients.

ECONOMIC PRACTICALITIES

Practically, a physician's inclination to game is often based on empirical assumptions that commonly are, in fact, incorrect. The physician may assume, for example, that a current denial of funding constitutes a permanent denial. However, in most cases this is not actually true. All utilization review systems have mechanisms for appealing lower-level decisions and, more importantly, it is rare for prospective review to result in a flat denial of funding for care that a physician seriously argues is necessary. Usually, either the physician's original plan is accepted after further discussion or else some mutually agreeable compromise is negotiated.[22]

Similarly, where funding actually is denied or unavailable, a physician may assume that further care for the patient is thereby precluded. This assumption, too, is

often erroneous, for it may be possible to find or invent alternative options. If an elderly widow is medically ready for discharge from the hospital but lacks adequate support services at home, the better remedy is to arrange for those home services, not to hold her indefinitely in a costly inpatient facility. A bit of inventiveness in recruiting family and friends can often solve the problem even in the absence of designated funds or formal programs for home care.

Even absent such alternatives, a denial of money does not entail a denial of care. When Medicare's hospital payment has been exhausted, the patient is not automatically discharged. The denial of further funding means only that continued hospitalization must be funded from somewhere else, whether by seeking money from a charitable organization, by adding to the hospital's burden of uncompensated debt, or even by expecting the patient to pay where he or she is obligated and able to do so. Similarly, a Medicaid refusal to cover well-baby care is not a denial of care to the baby, but of payment to the physician.

In these ways, the gaming that the physician may feel so urgently necessary is, as a matter of fact, quite avoidable. Gaming is often selected not because there is no other way to secure a needed resource, but because it is more obvious or convenient than searching for alternatives. Of course, there usually are alternatives: one can appeal, invent, negotiate, find money elsewhere, or provide services at no cost.

But here we encounter a major moral challenge. To demand this level of effort seems still to presume, as in our traditional view of fidelity, that the physicians are personally responsible to deliver resources to patients,

regardless of the costs to themselves or others. In the new economics of medicine, this requirement now seems untenable. We need to reexamine traditional obligations of fidelity as they concern resources.

FIDELITY RECONSIDERED

Our expectation that physicians should generously deliver other people's money and property to their patients is largely a product of history. Until relatively recently, physicians mostly had only their own care and concern to offer. As medical technologies emerged, generous third-party coverage, plus cost-shifting, generally made it possible for physicians, patients, courts and moral observers all to ignore costs. And yet, in the cold light of current resource constraints, it makes little sense to maintain this moral and economic anachronism.

The economic agents who provide health care's resources are not "intruders"[33] into the physician-patient relationship. In many ways, they make that relationship possible. The wisest, most skilled physician can do little without tools. And where the necessary tools are costly and scarce, and are owned or paid for by third parties, then physician and patient alike have an obligation to respect these agents' legitimate interests and resource restrictions.

If physicians are not obligated to deliver to their patients are that which they neither own nor control, then what do they owe? They owe what is their to give: their professional competence and loyalty as always and, in the new era of resource restrictions, their best efforts at advising and advocacy. Physicians have always owed their

patients medical advising and medical advocacy, of course, but now we must add an economic dimension, on both a clinical level and a profession-wide level.

On the clinical level, physicians need to advise their patients more closely concerning the economic changes in health care. In an important sense, patients are the "ultimate payers" for health care. As employees, they forgo salary or fringe benefits or cover the rising cost of health insurance; as consumers, they pay higher prices for products as businesses try to recoup the increasing cost of employees' health benefits; as taxpayers they see rising taxes or reduced government services as a deficit-ridden government seeks to trim what expenditures it can; as patients, they must directly pay higher copayments and deductibles and bear the medical consequences of cost-care tradeoffs. It is therefore fitting that patients play a much greater role in choosing whatever tradeoffs must be made.

To make these judgments, patients must know the price tags on their medical options. And this requires that physicians themselves become far more aware of the actual costs of care. They must be open about their own fees, and must try to learn the costs of the medications, tests, and other care they prescribe.[34] While this task may seem onerous, it is now necessary, for patients are entitled to know and to help decide the ways in which medicine's changing economics (including the conflicts of interest that this can create between patient and physician[5,35,36]) will affect their care. Where patients know more about their costs from the outset, they may even be less likely to pressure physicians inappropriately to "get the insurance to pay" for that screening test or cosmetic surgery that is expressly excluded by their policy.

Advocacy, like advising, is not a new concept in medicine. But when applied to economics, it carries some new responsibilities. Contrary to common views, advocacy does not require the physician simply to deliver resources to the patient. Rather, an advocate is "one who pleads, intercedes, or speaks for, or in behalf of, another."[37] While the physicians do not necessarily control or own the resources they seek for their patients, they can vigorously intercede on their patient's behalf.

Economic advocacy is no longer a personal favor that the physician may or may not choose to do for the patient. It is an important part of the physician's job, because otherwise the patient will have little or no access to essential monetary as well as medical resources. Thus, while we can no longer say that physicians owe their patients other people's resources, they do owe their own efforts to secure resources. The duty is now gaining recognition in commonlaw. In one case, Herbert Chew, a steel company worker who had undergone surgery, asked his surgeon, Dr Meyer, to document for his employer that Chew's absence from work was medically necessary. Meyer reluctantly agreed to have his secretary complete the necessary forms but, despite several inquiries and proddings from Chew, did not in fact send the forms until after Chew had had been fired from his job for failure to furnish that very documentation. The Maryland Court of Special Appeals noted that the physician's promise constituted an undertaking that, although perhaps gratuitously made, carried a duty to discharge the promise in a proper and timely manner.

The court also found another important basis for liability. In earlier times, the court argued, the plaintiff's claim might well have been summarily rejected, on the

basis that a physician's obligation ordinarily did not extend beyond their duty to use their best efforts to treat and cure. The traditional scope of the contractual relationship between physician and patient, however, has expanded over the years as a result of the proliferations of health and disability insurance, sick pay, and other employment benefits. Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.[38 (p. 832)] The physician therefore, the court concluded, has a duty to assist the patient in such economic matters. As a profession, physicians have further duties of economic advising and advocacy, namely, to help policymakers to write medically credible resource rules and to help change those that are not. Fortunately, such advisory efforts are already underway.[2,39,40]

CONCLUSION

In the end, then, I cannot recommend gaming as a strategy for coping with the admittedly frightening changes in medicine's economics. It is short-sighted, medically and morally hazardous, and usually unnecessary. Our real moral challenge now is to explore more closely the duties – and the limits – of economic advising and advocacy. Just as physicians should not be expected to commandeer others' money and property, so is it unreasonable to expect literally limitless efforts in appealing odd resource rulings, locating new sources of funding, or providing free care. Our agenda for the future, then, must

be not only to explore more closely the new fidelity of medical ethics, but also to consider how to forge a more rational health care structure, one that will not call for physicians so constantly to battle resource rules in order to secure care for their patients.

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Policy Review

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The doctor-patient breakdown: Trouble at the core of the medical economy.

Alper, Philip R.

WITH AMAZING SPEED, American medicine is evolving in uncharted directions. Managed care has transformed a "cottage industry" run by highly individualistic physicians into a far more controlled enterprise in which many other players wield major influence, both financial and professional. In the process, two medical economies with greatly differing perspectives and fortunes have emerged. Once mutually supportive, their relationship has deteriorated.

The core economy comprises the work and economic output of physicians and related professionals who diagnose and treat patients themselves. Though medical doctors are licensed and regulated, they have historically been accorded substantial autonomy and a primacy among peers, much like that accorded the captains of ships. Privileges and authority have been closely coupled with reciprocal obligations and responsibilities for both. The captain may command, but he is the last to leave the ship; physicians may give the orders, but they are not free to abandon patients or to refuse to give care in emergency circumstances. Physicians tend to work longer hours and more years than other professionals.

The peripheral economy provides the financing, management, and technology that support the care of patients. Enterprises as diverse as manufacturing drugs and writing health insurance policies all contribute to

patient care, though not independently. The face of modern medicine would be very different without this peripheral economy, but it is physicians who ultimately give the orders that are required to diagnose and treat patients.

The distinction between core and peripheral medical economies may appear to be either arbitrary or a misnomer, not least because the "peripheral" medical economy accounts for more than 80 percent of health dollars. Remarkably, until recently, the "core" earnings of physicians have remained fixed at 18 percent to 20 percent of health expenditures despite all the innovations of the past 50 years – Medicare, managed care, new technologies, and a doubling of the number of practicing physicians. The consistency of physician earnings in relation to the rest of the medical economy suggests that physicians have occupied a constant place even as the structure of health care has undergone dramatic change. The peripheral economy, meanwhile, has enjoyed remarkable success under managed care. In one fabled success story, nonprofit California Blue Cross was on the verge of insolvency in 1992 when it reinvented itself as for-profit WellPoint and went on to become a $6.77 billion corporation by 2001. The pharmaceutical industry has also enjoyed record profitability. On the other hand, Healtheon, now WebMD, failed to realize its dream of "capturing the doctor's desktop" and making itself indispensable to health care – despite the prestige and resources of its founders. And physician management companies, once Wall Street favorites, have failed spectacularly, leaving physicians skeptical of overarching controls.

But in general, the peripheral economy has been successful. And perhaps unsurprisingly, the success of the peripheral economy has provoked a backlash. State

medical associations in New York, Florida, and California are suing major managed-care insurers for a variety of practices, including take-it-or-leave-it contracting and retroactive lowering of physician fees. Frequent inflammatory statements from CEOs of Aetna and WellPoint have heightened the adversarial climate; the two companies have recently been embroiled in litigation over unfair business practices. Physicians have protested bitterly as their incomes have fallen and their autonomy has eroded in a managed-care world that blurs the roles of insurer, physician, and patient.

Ironically, managed care first emerged with the pledge to modernize and streamline medicine's cottage industry. Yet, in practice, fragmentation of authority has become pervasive. Employer associations and even individual employers sometimes set target standards – and specify dosages for medications. HMOS decide whether to pay for MRI scans, angioplasties, and bypass surgery. At the same time, alternative health practitioners – chiropractors, acupuncturists, herbalists, spiritualists, and a host of others – see more patients than all primary-care physicians and osteopaths combined. (Incongruously, many managed-care plans provide insurance coverage for a portion of this care.)

Reduced authority does not diminish physicians' legal liability. Most risk remains with the physician, rather than with the insurer or the employer who chooses and funds HMO insurance, because generally only physicians are legally empowered to direct patient care. More important, the Employee Retirement Income Security Act of 1974 (ERISA), which aimed to stimulate the growth of HMOs, continues to shield HMOs from responsibility even when there is reason to believe their actions have injured

patients. This exemption has been one of the key points of dispute in the congressional and White House wrangling over the Patients' Bill of Rights.

Is it the HMO, with its power to approve or deny payment, that is realistically at fault when coverage for care is withheld and the patient then fares poorly? Or is the physician who prescribes the treatment, but who has no authority to compel payment, responsible for the consequences? Is refusal of payment merely that – or is it tantamount to vetoing the physician's therapeutic recommendations? Passionate disagreement over such issues preoccupies the courts, the Congress, and the media. Not only is it a matter of who is in charge, but also of who should be in charge. The core medical economy and the peripheral medical economy, then, are often at odds. Yet it is hard to imagine how medicine can long be successful unless the two economies support each other. They are, however, drifting farther apart – and in certain respects, it looks like a reckoning is drawing closer by the day.

Searching for "best practices"

AT THE HEART OF THESE disputes is a concern that doctors do not entirely know what they are doing. For both financial and quality reasons, government and the managed-care industry agree that non-doctors should monitor and stimulate change in physician behavior.

There is a real basis for their distrust. John Wennberg's landmark study of "small area variation" revealed that hospital utilization for equivalent illnesses in Medicare patients was significantly higher in Boston than in New Haven. In other studies, hysterectomy and prostate surgery rates showed comparable discrepancies

from one locale to another – sometimes between adjacent towns. Angioplasty and cardiac surgery rates varied in similar fashion. In these and many other cases, there was no discernable medical reason to explain a disparity that seemed to be more a question of medical style than anything else. The physicians in question, despite their widely differing approaches, were all convinced that they were doing the right thing for their patients.

Intuitively, one would think there ought to be a "right" way, or at least a best way, to treat an infection or heart attack or to do a particular operation, but doctors seem to have trouble reaching agreement. Where treatment methods differ, are there negative consequences for patients? As medical journals considered the question, employers and insurers joined in the search for "best practices." Since employers finance their employees' health insurance, they reasoned, the employer ought to receive maximum value for his money. Insurers claim that better preventive practices and treatment yield better patient outcomes at a lower cost.

A new statistical tool – meta-analysis – aids the quest to identify the best treatments. Heretofore, it was difficult to compare one research project with another because studies are never identical; even minor differences in method make drawing conclusions difficult. Meta-analysis circumvents this problem by analyzing all published studies together, differences notwithstanding, and using statistical methods to extract useful information. Acceptance of meta-analysis is not universal, however. In one case, proponents reported unsuspected cardiac risks with two of the newer antiarthritic drugs. Opponents deny the significance of the report.

In any event, more powerful literature review has boosted the international effort to create an "evidence-based medicine." The Cochrane Collaboration, headquartered in Great Britain, coordinates input from around the world. Evidence-based medicine and best practices lead seamlessly to the creation of "clinical guidelines," templates for physicians to follow in the care of specific illnesses or clinical situations. Detractors call this cookbook medicine. Proponents praise it as state-of-the-art.

Medical specialty societies, the National Institutes of Health, as well as individual health plans and physician groups have produced several thousand guidelines. Because no guideline can encompass all cases – and because some guidelines remain more a matter of expert medical opinion than of proven fact – guidelines generally are considered advisory rather than mandatory. When medical cases end up in court, however, plaintiffs' attorneys portray clinical guidelines as immutable laws and deviation from them as malpractice.

Ironically, the original impetus to put medical practice on a sounder scientific footing, to limit variations in practice, and to improve patient outcomes came from within the medical establishment – not as a response to employers, insurers, or angry consumers. Academic physicians pioneered the application of scientific analysis to medical practice. Major journals, including the New England Journal of Medicine and the Journal of the American Medical Association, have devoted significant space to such efforts. But to their collective chagrin, the reform effort was commandeered by the employer-insurer-consumer coalitions that represent the managed-care movement. From the start, issues of quality, freedom, and money undermined the fundamental logic of this medical

revolution. The primary physician, for example, was loudly touted as the best person to decide when to make specialty referrals. After all, who knows the patient better? And who else could better understand the medical issues? Besides, hadn't research shown that specialists spend much more money than primary physicians when they treat the same illnesses? And weren't all parties in the coalition united in wanting to reduce rapidly rising medical costs? But in so designating the primary physician, the managed care movement also in effect recast that doctor's role in the system.

From personal physician to gatekeeper

FOR YEARS, the American Society of Internal Medicine had spoken For of the internist as a "personal physician," who would act as a patient's guide through the health system. It was clear that the relationship between doctor and patient would be voluntary and focused exclusively on the patient's welfare. The patient would command the total loyalty of the doctor. Managed care adopted the concept of the personal physician but changed its meaning in a major way.

The personal physician became the "gatekeeper" physician – a manufactured being with multiple loyalties extending far beyond the actual patient. Gatekeeper primary physicians were to approve referrals to appropriate specialists and authorize in-patient hospital care – all within the context of making the best use of each health plan's financial resources. As it later turned out, this often proved to be a thankless task, the primary physician serving as a barrier to consultations and treatments that patients desired but which did not fit the doctor's or health

plan's definition of medical necessity. During the patients' rights debate, a New York Times editorial praised the pending legislation because both the House and Senate versions "provide patients with prompt access to emergency care and specialists, such as pediatricians and gynecologists, without a referral from a primary care physician." Primary care case management is now seen as safeguarding the profits of insurance companies.

Many physicians worried about an inherent conflict of interest. A few chafed at being required to conserve resources without any influence on how such savings would be redirected. But none could argue that there wasn't waste in free-choice medicine. The American Academy of Family Physicians actively promoted the idea of managed care as a more rational way to maximize resources, rein in excesses found in specialty care, and bring payers and physicians closer to agreement on what constitutes good medical practice. They promoted family practitioners as the ideal primary care providers because of their wider range of services compared to internists or pediatricians. Federal and state governments allocated funds to support an increase in the proportion of primary versus specialist physicians from the one in three found in the United States to closer to two out of three, the typical ratio in other Western nations where per capita health expenditures were lower.

Initially, employers were reluctant to interfere with their employees' choice of physicians and hospitals. "Indemnity" insurance that paid a percentage of charges was the norm. In order to promote and lend respectability to a theoretically less expensive medical "system," Congress passed the HMO Act in 1973. It required businesses with more than 25 employees to offer at least one HMO option

among their health insurance choices. Physicians were promised access to more patients in return for discounted fees.

This was a marriage seemingly made in heaven. With access to discounts, employers escaped the double-digit rate of medical inflation in the 1980s. Insurers were able to limit their risk not only by securing discounts, but also by contracting with individual physicians or medical groups to supply a range of services at pre-determined rates, usually on a per-patient-per-month basis. These "capitation" payments essentially exported the insurance risk from the carriers to the physicians.

For the first time in medical history, physicians were pressed to consider the welfare of the entire population of patients served by an insurer's health plan as their collective responsibility – even if it meant not doing all they could for any individual patient. Thus, managed care began to affect medical practice on an unprecedented scale. Power passed from health professionals to insurers and coalitions of employers like the Pacific Business Group on Health.

Throughout this process, "trimming the fat in the system" was supposed to save money without harming patients. There were some notable successes. Ever since the 1946 Hill-Burton Act provided federal money for hospital construction, the number of U.S. hospitals had steadily increased to more than 7,000. Many had low occupancy rates and raised charges to offset high fixed costs. There seemed to be no political will to eliminate unnecessary beds and even less to close unnecessary facilities. As with military bases, local jobs and patronage were involved. Insurance carriers kept writing ever-larger

checks and passing on the costs to employers, who ultimately rebelled. Only then did contracting with hospitals for special rates for newly minted HMO or preferred provider organization (PPO) patients in advance of care replace paying blank-check "usual and customary charges." The result was the elimination of many surplus beds, closure of some facilities, and substantial savings. Medical inflation leveled off – for a while.

The California experience

ECONOMISTS MIGHT ARGUE that the customary laws of supply and demand also apply to physicians. If true, the relationship must be complex. According to the U.S. Census Bureau, California placed eighth in the U.S. in the per capita ratio of doctors in 1990. And yet managed care took firmest root in California – a state that did not have the greatest physician surplus, where fee discounts in exchange for volume should make the most competitive economic sense. Today, many doctors are leaving the state, which has now slipped to twelfth in doctor-patient ratio. Low pay and high living costs are cited.

Managed care is currently embattled not only with the Patients' Bill of Rights, but also with the more fundamental problem of a public tired of restrictions but unwilling to pay more for less intrusive management. Nevertheless, managed care should have considerable staying power, given its incentive structure that empowers insurers, acting on behalf of employers (and less clearly of patients), to bottom-fish the medical marketplace and pay the minimum acceptable contractual rates to physicians and other providers of care.

California Blue Cross has justified questionable practices – including unilateral retroactive fee reductions to physicians – as attempts to secure the most services from providers of care at the least cost, thereby benefiting consumers. As a result, the California Medical Association has been pursuing litigation against Blue Cross for several years. Judge David Garcia of the San Francisco Superior Court, who recently approved class action for the latest suit, noted the power imbalance between the plan and the physicians – and the threat to physicians' economic survival of not agreeing to treat the more than 2 million Blue Cross patients on Blue Cross's terms.

Until recently, employers considered nothing but price in choosing health insurance. One survey of insurance benefit managers showed that only 7 percent even considered quality of care to be a principal consideration in their choice of health plan. Physicians are incredulous that, in an age of gourmet foods, designer clothing, and custom housing, medical care has been relegated to lowest-dollar status. From the physicians' perspective, their vocation has been commoditized.

A recent study in the Archives of Internal Medicine tracked this process in San Mateo County, California, where medicine has experienced a managed-care-induced industrial revolution of sorts that has dramatically affected all aspects of medical practice. From 1993 to 1998, two very large purchaser organizations spearheaded a four-year progressive reduction in health premium rates throughout California. The Pacific Business Group on Health – comprising 45 large employers who purchase health benefits for 3 million employees, retirees, and their families – and CalPERS, the retirement fund which plays the same role for 1.2 million public employees, had

demanded and won reductions that then benchmarked the market rates for other insurers. Statewide premiums fell to 21 percent below the U.S. national average by 2000. San Mateo County, where the costs of living and of producing services are among the highest in the country, was especially impacted. The county now has the lowest cost-adjusted medical insurance payouts in the nation.

The funding gap has created a medical depression in San Mateo County, which has otherwise participated in the unparalleled wealth creation of the hitech boom. In centrally located Burlingame, the average house price is $810,000; physicians are failing to qualify for home loans. The renowned Palo Alto Medical Clinic, despite more lucrative insurance contracts than its neighbors and a well-funded foundation, was forced to stop accepting new patients for primary care in 2001 by an inability to attract new physicians to provide care.

Nearly three-fourths of the local populace now belongs to an HMO. As the least expensive non-charitable health choice, employers often offer only HMO coverage to their employees. If Medicare, Medicaid, and PPO patients are added, the number of patients treated under contract rises above 90 percent. One-third of the population is treated by the Kaiser-Permanente system, a prepaid multispecialty HMO 0 group practice. Given these numbers, only a handful of physicians do not participate in managed care. Robert Merwyn, president of Mills Peninsula Hospital in Burlingame, reports that 97 percent of patient billings at his hospital are subject to contractual discounting. Most of the remaining 3 percent of the charges are never paid.

All health providers have struggled to deliver care more economically. A majority of physicians have joined

independent practice associations (IPAS), which interface with insurance companies, negotiate payments to doctors, and set fees. Some are paid fee-for-service. Other physicians receive the per-head, per-month "capitation" payments in exchange for their agreement to provide all necessary care within their expertise around the clock. Capitation rates vary from $8 to little more than $20 monthly, except for infants and the elderly, where rates are higher.

IPAS save physicians from the Herculean task of dealing with the contracting, utilization review, and other administrative departments of multiple insurance carriers – a necessity unless the physician wants to put all his financial eggs in one or two insurance-carrier baskets. IPAS really are quasi-insurance organizations. In California, the recent Speier law has subjected them to solvency standards. With little beyond the doctors' own capital to support most of them, more than 20 IPAS filed for bankruptcy in zooo. More than half currently fail at least one of four tests of fiscal solvency, according to Daniel Zingale, director of the California Department of Managed Health Care. The CEO of one of the surviving IPAS concedes that he lacks the funds to audit the payments made by insurance carriers.

Physicians have seen their investment in IPAS disappear along with large chunks of their accounts receivable. (IPAS are less common outside California, but IPA failures in Texas, a state very medically different from California, shows that their vulnerability is not a local aberration.) IPA critics also observe that IPAS insert a layer of administration that consumes 10 percent to 15 percent of the insurance premium beyond the 20 percent

to 30 percent taken by health plans for administration and profits.

Pressure on physicians relates to physician supply, the extent of penetration of managed care, and the degree to which employers exert downward financial pressure on insurance premiums. Massachusetts, for example, has a high managed-care presence and 52 percent more physicians than the national average. Median physician earnings reported by the Massachusetts Medical Society were $219,300 in 1998, dropping to $120,600 in 2000 – and much lower than the median national physician earnings reported by the American Medical Association of $199,600 in 1997 and $194,400 in 1998. As HMO penetration increases, non-HMO insurance premiums tend to fall and financial stress is brought to bear on the system. California has six of the top 10 HMO counties in the nation, the highest being Sacramento with 75 percent penetration. San Mateo County is fourth at 72 percent.

The inefficiencies of managed care

TO WHAT DEGREE are these processes self-adjusting? Physician recruiter Martin Fletcher explains that a high managed-care presence is just as likely to undermine physician earnings in high cost-of-living areas (Boston and San Francisco) as in places where costs are low or marginal (Florida and Philadelphia). Pockets of acute distress occur when steep discounting, rapidly rising office expenses (up 61 percent in Massachusetts since 1994 after adjustment for inflation), and high cost of living combine. A physician exodus has become apparent in Boston, Buffalo, New York, and Sacramento County,

California, where the number of physicians dropped 20 percent from 1995 to 2000.

Until recently, most HMO patients were very happy. But approximately 80 percent are not ill and never experience the more burdensome restrictions of HMO care. At the same time, they benefit from low rates and freedom from paperwork, both of which are highly popular. Under California's Knox-Keene law, patient liability is limited to small co-payments, usually $5 to $15. Even if the health plan cannot pay its bills, physicians are prohibited from charging patients for care rendered but for which the physician was never paid. Nor can physicians immediately stop treatment.

Patients who are accustomed to the lower out-of-pocket costs of HMOS (which typically include prescription drug benefits) are loath to leave. A Kaiser Family Foundation survey reported in September 2001 that despite the brouhaha about patient rights, the majority of HMO patients remains satisfied. Since most of the discontent is found among the minority who use medical services more intensively, this is unlikely to change radically anytime soon.

Financial pressures normally stimulate economies, but physicians have encountered a paradox. Managed care has demanded and imposed elaborate bookkeeping, slowdowns in payments, difficult processing of patient eligibility, burdensome paperwork, and numerous bottlenecks to care, such as lengthy approval processes for individual prescriptions. Many of these provisions infantilize physicians, who must repeatedly seek permission from lesser-trained employees of health plans. The complexities also drastically raise overhead costs. Over the past two

decades, typical primary care office expenses rose from one-third to two-thirds of income, mainly due to the increased administrative demands of managed care and Medicare, both of which have been superimposed on other inflationary pressures.

Spyros Andreopoulos, former public affairs director at Stanford Medical Center, has examined the inefficiencies of managed care. California's problems are anything but unique, he writes, "a symptom of a widening national crisis driven by ill-considered actions and flawed market-driven health policies." Yet few such commentaries exist apart from the complaints of those working within the system.

Medicine has been fragmented by a maze of ever-changing contracts that may make economic sense to insurers but whose success often comes at the price of exporting additional costs and inconvenience onto physicians and patients. Given the implausibility of adhering to a dozen or more Aetna or Blue Cross or other carrier-specific drug formularies, practice guidelines, and preventive medicine schedules (and of altering them every time a patient changes insurance carriers), it appears that managed care has invented the horse – in the automobile age. Unfortunately, it is not yet politically correct to say so.

Physicians accuse managed care of not covering their costs and of "predatory pricing," while managed care responds that they are paying market rates. Blue Cross in California and Texas have aroused particular ire because of especially low payments and hard-nosed bargaining techniques, such as permitting contracts to lapse and then negotiating after enormous patient-care dislocations have

already taken place. The fee pressures of HMOS also apply to PPOS, which are misleadingly named because the preferred providers in these organizations are distinguished only by a willingness to sign the carriers' typically non-negotiable contracts.

Under the year 2000 Blue Cross PPO contract, reimbursement dropped from $5 per minute for the first five minutes to under $2 per minute for 45 minutes. For a full-hour consultation, the physician donated the last 15 minutes free of charge. Considering that office overhead for an internist generally runs at $130 to $150 hourly, it is hard to economically justify remaining in practice without creating something akin to a Medicaid mill. Other insurers also compress their fee schedules, similarly punishing physicians who spend more time with their patients or who accept complex time-consuming cases.

In California, six health plans control more than 8o percent of the market. Physicians have followed lawyers and accountants in "bulking up" to augment their negotiating clout, but unlike the Sutter Hospital Group with its statewide network of hospitals, they have not been successful in winning either substantially better rates or anything close to a pro rata share of rising health insurance premiums. The average capitation rate reached its pinnacle of $45 per patient per month in 1993, according to PriceWaterhouseCoopers. By 1999, it had fallen to $29 while the cost of living jumped 25.2 percent over the intervening six years.

"There's cost sharing between all of us – hospitals, insurers, doctors – because of growing inflation, pharmacy costs, etc.," PacifiCare spokesman Tony Salters told the Dallas Morning News. "Everyone is being affected by it."

There are some odd features to the relationship, however. Physicians in separate practices cannot bargain collectively because of anti-trust laws. They find themselves sitting at the table with far more powerful and wealthy competitors for the same dollars and, as in the story about the man who eats with a lion, discover that the lion eats first. At the moment, local lions are flexing their muscles. Stanford hospitals have canceled all HMO contracts and the University of California has cancelled its agreement to see San Mateo Medi-Cal patients. Such events make physicians nervous because they must take up the slack during contract disputes. Primary physicians become the ultimate guarantors of the system when specialty care becomes unavailable.

Some physicians, hoping to level the playing field, supported legislation by California Rep. Tom Campbell that would have allowed limited collective bargaining. The bill passed the House in 2000, surviving concerted Republican attempts to amend or undo it on behalf of the insurance industry (presaging the debate on the Patients' Bill of Rights). The Senate, however, did not act on it. In the process, the American Medical Association became convinced that its longtime Republican political allies were now so much in thrall to the insurance industry that they no longer cared about physicians. In zoo 2001, the AMA's campaign contributions to Democrats for the first time exceeded those to Republicans – and by a wide margin. This reflects an emerging reality: that the free market in which doctors compete against one another for patients is being transformed into a competition among insurance carriers that marginalizes physicians.

Managed competition vs. managed care

MOST AMERICANS RECEIVE health care on a fee-for-service basis, but a different delivery mode has been offered by the Kaiser-Permanente Plan, the nation's largest pre-paid group practice health plan that is responsible for the care of 8.1 million patients. This is the model that Stanford's Alain Enthoven had in mind when he conceived the idea of "managed competition" among a handful of integrated care systems analogous to the major automakers.

The Kaiser-Permanente structure was the original conception of "managed care," a large physician group setting its own professional standards, while financing and the provision of facilities are handled by the "Kaiser" component of the duality forged by Henry Kaiser and Dr. Sidney Garfield in the 1930S. Permanente physicians do not need formal permission to make referrals. They choose their own drug formularies and create their own preventive and treatment guidelines. In order to achieve this professional independence, the medical group went toe to toe with Henry Kaiser, who would have preferred to control what he paid for.

Apart from Kaiser-Permanente, managed care allows little or no participation by contracting physicians in setting standards for care or in choosing covered laboratories, consultants, preventive care guidelines, and formulary drugs. Typically, plans adapt guidelines like those of the Cancer Society or the Centers for Disease Control of the National Institutes of Health and implement them without external discussion. They hire pharmacy benefit managers to cut deals for the inclusion of drugs on

proprietary formularies. Physicians are then given their marching orders.

Management guru Peter Drucker, who wrote a seminal paper on the utilization of knowledge workers, would point to the lack of buy-in and participation by physicians. Neither morale nor quality of output is facilitated this way. Moreover, the managed care model that treats all physicians as essentially identical when they enter practice and then, years later, still considers them the same regardless of their achievements is unlikely to foster excellence. Likewise, with patients coming and going depending more on the results of employers' changing choices of insurance plans than on the quality of care or patient satisfaction, there seems to be little future in primary care medicine for physicians who thrive on long-term relationships. Indeed, it is hard to identify another business in which good service does not automatically lead to a loyal clientele and long-term relationships.

Managed care's impact in San Mateo County is pervasive. Most physicians are unhappy. More than half experienced actual declines in income and three-fourths failed to keep up with inflation in the 1990S. But dissatisfaction is statistically independent of falling income or medical specialty. Most physicians believe the quality of care has suffered and express frustration with their practices. Most would not want their children to become physicians. The financial and psychological data support the diagnosis of significant depression in both dollar and emotional terms.

The managed-care wars also buffeted Kaiser-Permanente. For three years, the company recorded unusual financial losses due to adverse experiences in

California and the East. According to the Archives study, San Mateo Kaiser Permanente physicians began to reflect the negativism of office-based community physicians, though to a lesser degree. They were far more likely to look with favor on their drug formulary and treatment guidelines, which they or their representatives played a part in creating. Of course, these physicians were preselected for a belief in managed care, or at least a willingness to work with it, so it is difficult to know whether non-Permanente physicians would be good job candidates for managed care in either venue. At present, there seems to be either a maladapted work force or an inappropriate system – or both.

Quality control

"THE SINGLE GREATEST error consumers make is to assume that if doctors disagree, one has to be wrong," says medical librarian Shirley Maccabee. That error also underlies the effort to "manage" medicine, to systematically identify the right way to do things and then call any deviation poor quality. In a sudden shift, employers are no longer satisfied with the lowest insurance premiums. They now want the highest quality for their money. The insurers sponsoring HMOs and PPOs now compete for recognition of the "quality" of their programs as measured by the percentage of women who get annual mammograms and Pap smears, the percentage of diabetics who see an eye doctor, and the number of patients with diseases like congestive heart failure who take specific drugs that are judged to show benefits. The privately owned National Committee for Quality Assurance (NCQA) rates plans by collecting data in a program called the Health Plan

Employer Data and Information Set (HEDIS) and makes the information available to the public online.

But such measures of quality control are problematic. Are primary physicians to hunt down people who don't want to come in? Are they to be penalized for choices made by the patient? Are checklists really a good marker for the overall quality of a physician's skill? Physicians are bewildered as non-physicians continually expand the lists and pontificate about quality, as if physicians are either too lazy or stupid to seek it themselves. It follows that the only reliable advocates for quality patient care are employers and insurers, and that their comprehension of medicine is as least as good as the physician's – so good, in fact, that they don't even need to see the patient to evaluate the quality of care.

But it's inconceivable that a doctor actually treats each patient differently according to the quality precepts of each insurer (Blue Cross backache, Aetna asthma, and Cigna congestive heart failure, for example). It would be utterly confusing to tailor each patient's care to the specific desires of his insurer. Nevertheless, statistics are collected and touted in the marketplace as proof of the quality of one insurer's product over the other. Claimed differences in the results of treatment for asthma, heart failure, or diabetes are more likely to be statistical accidents than indicators of real differences in quality rendered by the doctors seeing each plan's patients. Distortions are guaranteed because NCQA's "Quality Compass" is a marketing tool for employers with more public relations than science behind it. Absurdly, in 2000 and 2001, the NCQA reported great progress in HMO quality at the same time that public anger against HMOs

was mounting rapidly – and the average HMO stock price rose 25 percent.

Medical practice and the human beings who deliver care are surely imperfect. But does that justify shifting so much clinical, financial, and administrative control to non-physicians with enormous vested interests of their own? Should all doctors have to think and do alike in order to be considered good doctors? Should patients put their lives in the hands of physicians who are intent on polishing their report cards under the benevolent guidance of employer-insurer management? That these questions are barely debated points to one of history's greatest bait-and-switch operations. Insurers who have no commitment to any geographic area and who cancel policies at will when profits drop have been made the guardians of medical quality even at the local level. Industry now vies with government in regulating medicine, as Betty Leyerle has eloquently described in The Private Regulation of American Healthcare (M.E. Sharpe,

Whither health care?

WHERE, THEN, IS American medicine headed? If present trends continue, the widespread dissatisfaction with both income and the quality of professional life will extend the decline in applicants to medical schools beyond the nearly 30 percent drop over the past five years. With an average medical school debt of $97,400 in 1999, fewer physicians will come from the middle class because of an unfavorable risk-reward ratio. The wealthy will avoid medicine as a profession, and the need for scholarships to enlist students will grow.

Consumers and non-doctors will play a greater role, with more liberal licensure for non-physician providers of care and more consumer influence over tests and treatments. Consumers will expand self-ordering of hi-tech tests such as total body scans and will win insurance coverage when there are positive findings. Managed care will continue narrowing the role of primary physicians as nurse practitioners and physician assistants perform some of their work for lower fees. This will continue until earnings drop low enough to make primary physicians, with their greater ability to diagnose and treat, more economical than non-physician substitutes.

The use of hospitalists, hospital-based medical specialists for in-patients, will also grow and relegate most primary physicians in metropolitan areas to office practice only. Specialists will continue to dominate American medicine because of public demand for new technology (but they will not regain their former authority over fees). Owing to the use of lower-cost and lesser-trained substitutes, fewer people will have primary physicians for more than short periods. The sole exception will be patients with complex problems involving multiple specialists, in which case primary physicians will be required to integrate care.

Employers and insurance carriers will change tactics in response to anti-HMO sentiment. Health plans are already starting to distance themselves from tight control of consumer choices. Higher co-pays rather than denials of service will continue to grow. Physicians will need to contend with angry patients when their recommendations do not accord with each plan's favored approach, thereby raising out-of-pocket costs. Patients will need to contend with angry physicians as other plans follow PacifiCare's

lead in rating doctors on how low they can keep out-of-pocket costs for patients. Barring catastrophic events that drastically increase the number of uninsured from its current level of 43 million, neither Congress nor the administration will even discuss a single-payer, one-size-fits-all health system.

The outlook for the peripheral medical economy looks bright because the freedom to innovate continues. Health insurance and pharmaceutical and medical device manufacturing, unlike the provision of medical or hospital services, have escaped the price controls of the Mediplans and the major financial hits of managed care. Surging health insurance premiums – up 11 percent from 2000 to 2001 – did not significantly benefit physicians.

Most physicians face major impediments to innovation because, under managed care, compliance has greater survival value than creativity – at least in the short run. Denial of services is viewed as a strike, something most physicians do not favor. The antitrust laws significantly inhibit joint action. Some specialists, notably those in renal dialysis and cancer care, have established their own businesses and negotiate collectively for their services. Primary-care innovation is far less common and has mainly involved substituting lesser-trained personnel for doctors. Furthermore, most physicians seem to have neither interest nor aptitude in creating new business arrangements. Physician executives are increasing in number, but, lacking broad business experience and divorced from patient care, they have an uncertain future.

It appears that the closer to the patient one gets, the less desirable the job becomes, the more the risk of burnout increases, and the greater the appeal of non-medical

jobs at often higher salaries. But high-earning health care executives with an average income of $800,000, not counting deferred compensation, are reportedly seeking retirement before age 65 – also due to job pressures. Paradoxically, health care delivery has grown more dysfunctional even as medical science continues to make unprecedented gains.

As Richard Nixon once said, "Solutions are not the answer." The statement seems applicable to medicine, since no nation has produced a model health system. The U.S. has so far avoided the single-payer "solution" that is finding favor with an increasing number of frustrated physicians. Instead, U.S. medicine continues to make medicine more "businesslike." Given the trends – the majority of young physicians now taking jobs rather than setting up their own practices, increasing educational debt, less willingness to commit oneself entirely to medicine at the expense of family, and fewer opportunities to remain independent – Alain Enthoven's proposal of "managed competition" makes sense.

Enthoven envisioned the appearance of other mega-plans modeled after Kaiser-Permanente. But the Kaiser-Permanente system has not been replicated; risking capital in enterprises with limited upside potential and no good exit strategies remains unappealing. What's more, Kaiser-Permanente itself has recently withdrawn from several eastern states and closed facilities due to large financial losses.

Managed care's principal accomplishment has been a temporary slowing of surging health care expenditures. At the same time, HMO growth has stalled and physicians, patients, and their employers are all frustrated. It's

unsurprising that a system that never underwent prototype field-testing before widespread implementation is encountering so many problems. Nor is it surprising that turning a blind eye to waste, duplicative effort, and inefficiency has allowed these problems to multiply.

San Mateo County physicians overwhelmingly agreed that the quality of time spent with patients has deteriorated since the mid-1990S. Much of their time now must be spent choosing drugs that won't be rejected or require lengthy negotiation for approval, checking lists of network consultants, obtaining permission for tests and referrals, and explaining the mysteries of the system that no patient learns in advance. The regulatory hurdles divert attention from what brought the doctor to medicine in the first place and leave both parties dissatisfied. Alternative practitioners are increasingly popular partly because they have fewer distractions and can focus attention more fully on their clients.

Currently, physicians are treated almost generically in high managed care areas. Patients eventually feel the depersonalization experienced by the doctor. PacifiCare is trying to counter this with bonuses for physicians who win high marks from their patients. Whether this will inspire kinder and gentler care is an open question. At least some physicians are offended by popularity contests with insurance companies as scorekeepers. In their view, marketing becomes too important and hard-earned professional competence gets taken for granted.

Continued travel down the current managed-care road will require a new type of doctor with sufficient detachment to function comfortably in the new environment. How well the humanitarian impulses that motivate most

physicians can survive this rather dehumanizing process is unknown. It is a critically important question because doctors must be allowed to be doctors if they are to leaven their technical skills with the empathy that is needed to truly heal patients. For this to happen, the two medical economies must converge and cooperate. The biggest challenge will be to use free-market mechanisms to control costs, improve efficiency, and create a climate in which physicians and patients both can thrive.

M.D., Inc.

TO DO THIS, should doctors become corporate employees? California is one of 37 states that ban the corporate practice of medicine, meaning that non-physicians cannot be the owners of businesses in which physicians treat patients. The law is based on the premise that physicians should be free to exercise professional judgment and remain fully accountable for their actions. But this view has been increasingly challenged as antiquated, anti-efficiency, and blind to current market realities.

Economists and lawyers who wish to reverse the corporate ban see medicine as no different from other business endeavors in which corporate structure has proved useful. Strikingly, however, they have failed to investigate why Kaiser-Permanente, the nation's largest HMO, deliberately chose not to have physicians work for the Kaiser Corporation. Permanente Medical Group historian Steven Gilford explains that the doctors were ready to walk away from i years of work with Kaiser unless they were allowed to retain control of patient care and resource allocation.

Moreover, fluctuations in the business cycle – the idea of hospitals coming and going, personal and business bankruptcies afflicting providers of care, and sudden disappearance of services as corporate assets are redeployed in response to changing market conditions – is a dubious basis for health policy. Sick patients are not likely to be persuaded that the benefits of brand-name medicine are worth the risks. Nevertheless, the experience in states that do allow corporate medical practice does merit scrutiny.

The redesign of health care would benefit from a human resources approach that is free of ideological bias and ill will toward physicians. California is experiencing such growing animosity. The state's HMO czar wants consumers to know whether their doctors are facing insolvency. State Sen. Jackie Speier feels that the solvency legislation she sponsored is being perverted and will fatally undermine doctors' negotiating position with managed care if their private financial status is made public. News coverage insinuates that Speier is coddling doctors. But such coverage proceeds from the widespread (and mistaken) belief that to be pro-consumer, one must be anti-doctor.

A neutral analysis of the doctor's job and the qualities needed to perform it is essential. Efficiency studies should follow. Managed care has shunned this aspect of management because the industry perceives doctors as outside contractors whose welfare and productivity are not of direct concern. Doctors are expensive to train, however; their time would best be spent caring for patients rather than doing paperwork. In order to meet the needs of a varied public, doctors should not be expected to be clones of each other. Checklists should not replace the doctor's

brain if the doctor is to remain clinically sharp. Freedom to prescribe should permit taking advantage of the subtle differences among similar pharmaceuticals to suit the specific needs of each patient. Creativity should not be extinguished in the service of compliance. Accountability – a virtue – becomes a vice when it overwhelms the person subjected to it.

Moreover, excessive regulatory control favors large, well-funded companies and may even put smaller companies out of business without any contest in the marketplace. Since small organizations cannot spread compliance costs in dollars and manpower across a large base, overregulation threatens the economic viability of otherwise healthy solo and small-group practices. Patients who prefer this kind of care may thus experience both a decreased selection of caregivers and higher costs as regulatory expenses pad the ultimate bill.

No solutions have yet emerged because, as yet, there is no agreement on goals. Policymakers should carefully consider the long-term consequences of decoupling the medical economy from the surrounding local economy, as occurred in San Mateo County. Lethal competition among physicians, the young cannibalizing the practices of their seniors with no premium awarded for achievement and experience, promises to compromise the quality of care – as does below-cost contracting for essential services. The economics of putting caregivers at personal risk with no ability to react rapidly to sudden cost increases (such as the recent jump in malpractice premiums) must also be addressed. The emotional needs of physicians and of patients, including the ability to forge long-term relationships, should not be ignored, because they determine the ultimate acceptance of any system. And the question,

"How does being treated by a depressed doctor measure up against flying with a depressed pilot?" should be taken seriously. Most of all, a vibrant, creative, and pluralistic medical profession should not be sacrificed cavalierly.

Managed care has a great deal of work to do if it is to justify the pretension embodied in its name. Legislative assistance may be needed to redirect medical competition toward healthier ends. In the end, a failing core medical economy will not long support the massive health care edifice that surrounds it.

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